BEFORE THE WEST VIRGINIA BOARD OF MEDICINE

WEST VIRGINIA BOARD OF MEDICINE,
PETITIONER,

v.

LOUIS JOHN DEL GIORNO, M.D.,
RESPONDENT.

ORDER

This proceeding arises under the West Virginia Medical Practice Act, West Virginia Code §30-3-1, et seq. It is a disciplinary proceeding involving the status of the license to practice medicine and surgery in the State of West Virginia of Louis John Del Giorno, M.D. The West Virginia Board of Medicine ("Board") is the duly authorized state agency to oversee and conduct physician disciplinary hearings pursuant to the provisions of West Virginia Code §30-3-14.

This proceeding was initiated by a Complaint and Notice of Hearing issued on behalf of the Board dated July 24, 2009. The hearing was convened on December 15, 16, and 17, 2009, in the offices of the Board at 101 Dee Drive, Charleston, West Virginia, before Hearing Examiner Jennifer Narog Taylor. The Petitioner was present by its Executive Director, Robert C. Knittle, and represented by its disciplinary counsel, John A.W. Lohmann. Petitioner presented as witnesses Leslie A. Higginbotham (now Thornton); Robert C. Knittle; Louis Del Giorno, M.D.; David A. Potters; Daniel Doyle, M.D.; Daryl LaRusso, M.D.; Allen E. Meske, M.D.; Eric Glass, D.O.; John W. Ellis, M.D.; Phillip C. Van Dongen, M.D.; Brandt H. Williamson, M.D. Respondent testified on his own behalf and presented Robert C. Knittle as his witness.

Fifty six (56) exhibits were entered in the record by Petitioner, 1-16, and 18-57. Eighteen exhibits presented by the Respondent were entered in the record. One exhibit was lodged with the Hearing Examiner.

A stenographic record of the hearing was prepared pursuant to 11 CSR 3 12. Petitioner's Proposed Findings of Fact and Conclusions of Law and Recommended Decision was submitted to the Hearing Examiner, as were Respondent's Summary Brief to Administrative Hearing, Petitioner's Response to Respondent's Summary Brief to Administrative hearing, and Respondent's Reply to Petitioner's Summary Brief of Administrative Hearing. In accordance with 11 CSR 3 13, the stenographic record of the hearing, all exhibits, and all pleadings were provided to Board members other than those members comprising the Complaint Committee at the time of the Complaint Committee's "probable cause" finding regarding Dr. Del Giorno, those members being Dr.'s Michael Ferrebee and Badshah Wazir, and Reverend Richard Bowyer.

In April, 2010, prior to the Board's regular meeting on May 10, 2010, and pursuant to 11 CSR 3 11.5(p), the Recommended Findings of Fact, Conclusions of Law and Recommendation of Hearing Examiner was provided to Board members other than the aforementioned Complaint Committee. At the Board's regular meeting on May 10, 2010, where a quorum of the Board was present and voting, the Board thoroughly considered all of this information , and in accordance with 11 CSR 3 7, reached its decision. Dr. Slemp and Beth Hays, M.A., were not present for the May 10, 2010 Board meeting, and Dr.'s Ferrebee and Wazir, and Reverend Bowyer did not participate or vote in this matter due to their membership on the Complaint Committee at the time of the "probable cause" finding regarding Dr. Del Giorno. Dr. Wade presided.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND RECOMMENDATION OF HEARING EXAMINER

The Board adopts page 1 and the first two (2) lines of page 2, with the exception that one of the allegations is incompletely and inaccurately stated, and is not adopted, that being "by prescribing prescription drugs in a manner other than in good faith and in a therapeutic manner". The actual allegation is "prescribing... other than in good faith and in a therapeutic manner in accordance with accepted medical standards and in the course of the physician's... professional practice." See West Virginia Code § 30-3-14(c)(13), and the first page is modified to so state.

PROCEDURAL HISTORY

The Board adopts the Procedural History on pages 2 and 3, with the modification that the word "discover" in the first paragraph is changed to "discovery", for accuracy and clarity.

RULINGS ON OBJECTIONS

The Board adopts the Rulings on Objections on pages 3 through 6, with the modifications that on page 4 under **Hearsay** the word "theses" is changed to "these" for accuracy and clarity and on page 5 under **Sequestration of Witnesses** in the description of Rule 703 of the West Virginia Rules of Evidence, the word "make" is changed to "made" for accuracy and clarity.

ISSUES

The Board adopts the Issues on pages 6 and 7, with the exception that one of the issues, c., is incompletely and inaccurately stated, and is not adopted, that being "Prescribing prescription drugs in an manner other than in good faith in accordance with accepted medical standards in violation of W.Va. Code §30-3-14(c)(13)..." The actual issue is "Prescribing

prescription drugs in a manner other than in good faith and in a therapeutic manner in accordance with accepted medical standards and in the course of the physician's...professional practice, in violation of W.Va. Code §30-3-14 (c)(13)..." The issue c. is modified to so state.

WITNESSES AND EXHIBITS

The Board adopts the sections Witnesses and Exhibits on pages 7 through 9, with the modification that on page 8, the initials for the Medical records on Patient No. 9 are changed from "PWH" to "PW", for accuracy and clarity.

INTRODUCTION

The Board adopts the Introduction on pages 9 and 10.

FINDINGS OF FACT

The 98 Findings of Fact on pages 10 through 56 are adopted, with the following modifications. In Finding of Fact 2 On page 10, the sentence "He was board certified as a family practitioner from 1986 until 2002, when the certification expired." is stricken and not adopted and inserted in lieu thereof and adopted is "He testified 'The original certification was in I believe '86, seven years. So, it expired in I believe 2002.'" for accuracy and clarity.

In Finding of Fact 4 on page 11, and also in Finding of Fact 49.a. on page 31"opiods" is stricken and not adopted and inserted in lieu thereof and adopted is "opioids" for clarity and accuracy.

In Finding of Fact 6 on page 11 "of" is inserted and adopted between "medical director" and "the" and a comma is inserted and adopted after "Robert Knittle", in both cases for clarity and accuracy.

In Finding of Fact 9 on page 12, the sentence "The Respondent filed his Answer on September 9, 2009." is stricken and not adopted and inserted in lieu thereof and adopted is "The Respondent's Answer was received on October 2, 2009." for accuracy and clarity.

In Finding of Fact 17 on page 16, "Board's" is stricken and not adopted and inserted in lieu thereof and adopted is "Boards", for accuracy and clarity.

In Finding of Fact 36 on page 24, in the third line after "that" the words "he that" are stricken and not adopted, for accuracy and clarity.

In Finding of Fact 38 on page 24, in the third line from the bottom "Respondents" is stricken and not adopted and inserted in lieu thereof and adopted is "Respondent's", for accuracy and clarity.

In Finding of Fact 46 on page 29, the words "drugs abuse" is stricken and not adopted and inserted in lieu thereof and adopted is "drug abuse", for accuracy and clarity.

In Finding of Fact 54 on page 36, in the first line "form" is stricken and not adopted and inserted in lieu thereof and adopted is "from", for clarity and accuracy.

In Finding of Fact 55 on page 36, the words in quotations "went on a drinking binge and apparently fell down during this episode" are stricken and not adopted and inserted in lieu thereof and adopted is "went on a drinking binge-and apparently fell during this episode. Pulled out her eyelashes." for clarity and accuracy. Also, "The noted that Patient 16 was seeing her previous psychotherapist" is stricken and not adopted and inserted in lieu thereof and adopted is "The notes state that Patient 16 went to see her previous psychotherapist.", for clarity and accuracy.

In Finding of Fact 56b on page 38, in the first line "in" is stricken and not adopted after "chart entry", for clarity and accuracy.

In Finding of Fact 68 on page 45, in the first line "SR" is stricken and not adopted and "HW" is inserted in lieu thereof and adopted, for clarity and accuracy.

In Finding of Fact 72, on page 48, "which is a safeguard and good medical practice in treating persons with opiates" is stricken and not adopted and inserted in lieu thereof and adopted is "which 'is one of the key safeguards and good medical practices in treating patients in general and especially in treating patients in a case like this where part of the task is to sort out who needs opiates for chronic pain, for therapeutic use, and where there could be a problem of addiction and diversion.'", for clarity and accuracy.

In Finding of Fact 77, on page 50, "disturbing" is stricken and not adopted and inserted in lieu thereof and adopted is "questionable", for clarity and accuracy. "This practice often leads to a dysfunctional use of substances." is stricken and not adopted, for clarity and accuracy.

In Finding of Fact 82, on page 51, insert and adopt at the beginning of the Finding of Fact "After the entire section of West Virginia Code §30-3-14 (c)(13) was read to him," for clarity and accuracy.

In Finding of Fact 87, on page 52, "and from his failure to conform to the current principles of medical ethics of the American Medical Association" is stricken and not adopted, for clarity and accuracy.

A Finding of Fact 99 is inserted and adopted on page 56 as follows, "By letter of December 18, 2010, Dr. Del Giorno advised the Executive Director of the West Virginia, Robert Knittle, that 'I have decided to allow the General Counsel for the Board of Medicine, Ms Rodecker, to present the final case to the Board of Medicine.'"

A Finding of Fact 100 is inserted and adopted on page 56 as follows, " Dr. Del Giorno is unqualified to practice medicine in the State of West Virginia."

DISCUSSION

The Board adopts the Discussion on pages 56 through 63, with the following modifications. On page 60, in the last line "Potter" is stricken and not adopted and "Potters" is inserted in lieu thereof and adopted, for clarity and accuracy.

On page 62, "inherent to a physician" is stricken and not adopted and inserted in lieu thereof and adopted is "inherent in a physician", for clarity and accuracy.

On page 62, "Dr. Del Giorno has practiced medicine for 28 years." is stricken and not adopted, as the fact that he has practiced medicine for 28 years is not a mitigating circumstance. A mitigating circumstance is one which reduces the degree of culpability or blameworthiness.

On page 62, "Although he lost his licenses in two other states as a result of 'tax matters' is stricken and not adopted, and inserted in lieu thereof adopted is " Although his Florida license was surrendered, his New York license was revoked, and he testified that his Maryland license was suspended because of a 'tax issue'", for clarity and accuracy.

On page 63, "He is a sole practitioner and, as he has noted, his entire livelihood depends on this decision." is stricken and not adopted as these facts are not mitigating circumstances. A mitigating circumstance is one which reduces the degree of culpability or blameworthiness. Inserted in lieu thereof and adopted is "He did weed out and discharge a number of patients who were not taking controlled substances appropriately or were otherwise non-compliant with his requirements.", as this is a mitigating circumstance.

On page 63, the Board notes that it would violate the law (West Virginia Code §30 -3-14(j)(4)) to adopt the Hearing Examiner's recommendation of restricting permanently the prescribing of controlled substances by Dr. Del Giorno. Such a restriction may be imposed for a maximum of ten (10) years, and it would not protect the public for Dr. Del Giorno to be allowed

to prescribe controlled substances again in ten (10) years. Therefore the Board strikes and does not adopt any portion of the paragraph wherein the Hearing Examiner's recommendation is made, with the exception that the Board adopts the recommendation that the Respondent be assessed the reasonable costs and expenses of this matter.

CONCLUSIONS OF LAW

The twenty (20) Conclusions of Law on pages 63 through 68 are adopted by the Board with the following modifications. In Conclusion of Law 11., "other than in good faith and in a therapeutic manner and thus is in violation of W.Va. Code §30-3-(c)(13)" is stricken and not adopted and inserted in lieu thereof and adopted is "under state or federal law, other than in good faith and in a therapeutic manner in accordance with accepted medical standards and in the course of the physician's...professional practice, in violation of W.Va. Code §30-3-14(c)(13)." for accuracy and clarity.

In Conclusion of Law 15, "has had the effect" is stricken and not adopted and inserted in lieu thereof and adopted is "has the effect", for clarity and accuracy.

A new Conclusion of Law 16 is added and adopted to read as follows: "It is clear that a physician who issues a prescription for controlled substances for non-medical purposes is not acting in the course of his professional practice only. The fact that the transaction may take place in the physician's office, that prescription forms are used, and that the transaction has the outward appearance of medical practice does not make it one occurring in the course of a professional practice. *People v. Goldberg,* 369 N.Y.S.2d 989 (1975)" for clarity and completeness.

The Conclusions of Law of the Hearing Examiner 16 through 20 are renumbered 17 through 21 and are so adopted.

RECOMMENDED DECISION

The paragraph on page 68 is stricken and not adopted and inserted in lieu thereof and adopted is "Based upon the foregoing findings of fact and conclusions of law, even taking into consideration mitigating factors, the West Virginia Board of Medicine finds that it is proper and essential and in the public health, interest, welfare and safety that the license of Louis J. Del Giorno, M.D. be REVOKED, effective June 1, 2010."

This change is made to better protect the public inasmuch as the law does not permit the Board to permanently prohibit Dr. Del Giorno from prescribing controlled substances, as the expert witness Dr. Doyle and the Hearing Examiner have recommended. This is clearly essential, and the only way to arrive at this outcome is to revoke his license. The records show his prescribing practices to be horrifying, including but not limited to prescribing controlled substances to a thirty (30) year old patient who on an initial visit announced to the Respondent that the patient snorted cocaine the week before and took her father's Oxycontin the day before, prescribing controlled substances to patients who had evidence of addiction, failing to check hospital records where a number of his patients to whom he was prescribing controlled substances were being treated for overdoses, almost never doing base line urine screens for a patient population that was being treated for chronic pain, prescribing controlled substances while ignoring "red flags" suggesting intravenous drug use, poor documentation as to the need for pain medication other than more pain, more pain medicine, prescribing controlled substances to a heroin user, making a note that the patient is doing well on more medication and six (6) days

later noting that the patient has committed suicide, and an overall pattern of "extremely dangerous" practices, as described by Daniel Doyle, M.D. (Tr. v. 2, p. 34)

The expert witness, Dr. Doyle, opined that "a number of the physicians in the community who are familiar with Dr. Del Giorno comment that he is intelligent, he is well-informed, that he knows what he is doing. And, so, the implication is that this is not an issue of ignorance or lack of education. And, so, then the question is what is going on. And my concern is that to take the most favorable explanation that Dr. Del Giorno is not being honest with himself in what is going on and that he is in a state of denial about his practice and the impact on the community." (Tr. v. 2, pp 84-85) The record in this case in West Virginia shows his record in Florida, Maryland, and New York to be dismal as well.

Under all these circumstances, in the judgment of the Board, with no dissenting votes, the only appropriate sanction to impose is revocation. It is consistent with the case *Berlow v. West Virginia Board of Medicine,* 458 S.E. 2d 469 (W. Va. 1995) for the Board to determine the appropriate sanction to impose, so long as the Board gives an explanation for the change, which has been done herein. Moreover, under the Board's rule 11 CSR 3 11.5 (p) the responsibility of the Hearing Examiner is to preside at the hearing, to cause to be prepared a record of the hearing so that the Board may discharge its functions. The Hearing Examiner's responsibilities are to prepare recommended findings of fact and conclusions of law for submission to the Board. The rule does not reference the Hearing Examiner being required to make any recommendation for sanctions. 11 CSR 3 14.3 permits the Board to "adopt, modify, or reject" the findings of fact and conclusions of law submitted by the Hearing Examiner, and again, does not mention a recommended decision.

The paragraph on page 69 is stricken and not adopted and inserted in lieu thereof and adopted is "Respondent shall be required to pay the costs of these proceedings, including but not limited to the Hearing Examiner, the court reporter and expert witness, and all other costs of investigation and prosecution of this matter, to be paid by Respondent to the Board within thirty (30) days of issuance of an Invoice by the Board."

The paragraph is rewritten and the extent of the costs to Dr. Del Giorno reduced from the Hearing Examiner's recommendation, because there were no security costs at the hearing and there will be no attorney advisor costs because it was not necessary for the Board of Medicine to contract with an attorney advisor to provide this service in this case.

ORDER

In order to give time to Dr. Del Giorno to notify his patients, the license to practice medicine and surgery in the State of West Virginia, License No. 16605, is REVOKED effective June 1, 2010, at 12:01 a.m.

Within thirty (30) days of issuance of an Invoice by the Board, Dr. Del Giorno shall pay to the Board the costs of these proceedings, including but not limited to the Hearing Examiner, the court reporter and expert witness, and all other costs of investigation and prosecution of this matter.

The foregoing was entered this 14th day of May, 2010.

John A. Wade, Jr., M.D.
President

Catherine Slemp, M.D., M.P.H.
Secretary

BEFORE THE WEST VIRGINIA BOARD OF MEDICINE

WEST VIRGINIA BOARD OF MEDICINE,

PETITIONER,

v.

LOUIS JOHN DEL GIORNO, M.D.,

RESPONDENT.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND RECOMMENDATION OF HEARING EXAMINER

This is a matter involving a disciplinary complaint filed by the Petitioner, the West Virginia Board of Medicine ("Board"), against the Respondent, Louis J. Del Giorno, M.D. The Petitioner alleged that the Respondent violated the West Virginia Medical Practice Act and/or rules of the Board by failing to practice medicine with that level of care, skill and treatment recognized by a reasonable, prudent physician engaged in the same or similar specialty as being acceptable under similar conditions or circumstances; by demonstrating professional incompetence, by prescribing prescription drugs in an manner other than in good faith and in a therapeutic manner; by engaging in unprofessional, unethical and dishonorable conduct of a character likely to harm the public, which said conduct had the effect of bringing the medical profession into disrepute; and by failing to keep adequate written records justifying the course of his treatment; by committing acts and/or a pattern of acts during the course of his medical practice which, under the circumstances, are considered to be grossly incompetent, ignorant and negligent and constituted malpractice. The Petitioner seeks

revocation of Dr. Del Giorno's license to practice as a physician, as well as costs and expenses of the proceeding.

PROCEDURAL HISTORY

The Petitioner, the West Virginia Board of Medicine, filed its Complaint and Notice of Hearing on July 24, 2009. The Respondent, Louis J. Del Giorno, filed his Answer on September 9, 2009. The parties then engaged in discover, which included the taking of numerous depositions, an exchange of discovery, witness lists and anticipated exhibits.

The undersigned hearing examiner conducted a full hearing in the matter from December 15 through December 17, 2009, in the offices of the Board of Medicine at 101 Dee Drive, Charleston, West Virginia. A stenographic record of the hearing was prepared pursuant to the requirements of 11 CSR 3 §12.1. The Petitioner appeared through Robert C. Knittle, its Executive Director, and John A.W. Lohmann, its counsel. The Respondent appeared in person, *pro se*.

As a preliminary matter, the undersigned noted that Dr. Del Giorno had requested that a subpoena be served upon Dr. Daryl LaRusso, a potential witness. The undersigned noted that Dr. LaRusso had made an *ex parte* telephone call to her and asked questions regarding the subpoena, which she answered in an impartial manner. The morning of the hearing, the Board received a letter from Patricia Hofstra, counsel for Dr. LaRusso, stating that he did not have the evidence sought by the Respondent. Without objection by the parties, the letter was made a part of the record as Hearing Exhibit No. 1. (Tr. vol. 1, p.17.)

Dr. Del Giorno had raised several objections during the course of the evidentiary depositions taken in this matter. After some discussion, all parties agreed that the Hearing Examiner would address the objections individually in the written opinion. (Tr. vol. 1, p. 20.) The Board then moved that any and all patient names be redacted from the official record and the exhibits. There being no objection by the Respondent, the motion was granted. (Tr. Vol. I, p. 26.)

There being no other procedural issues to address, the Board presented numerous witnesses and exhibits in support of its position, and the Respondent presented his own witnesses and evidence as a defense. The undersigned admitted into evidence numerous exhibits offered by the Board and the Respondent, all of which are listed herein below.

Upon the conclusion of the hearing, the Hearing Examiner established a briefing schedule, and directed that the parties simultaneously file proposed findings of facts, conclusions of law and supporting briefs. All of the proposed findings and the responses thereto were timely filed by both parties.

RULINGS ON OBJECTIONS

Reputation Opinion: The Respondent objected to questions posed to the witnesses regarding Dr. Del Giorno's reputation in the community for truthfulness, arguing that such opinions constituted prejudicial, irrelevant hearsay. Reputation evidence is generally admissible in matters where character is a relevant issue. "In all cases in which evidence of character or a trait of a character of a person is admissible, proof may be made by testimony as to reputation or by testimony in the form of an opinion." Rule 405(a), *W.Va. Rules*

of Evidence. This rule has been held to apply to testimony offered by one competent to form a professional opinion of the character of the person in question. *Dietz v. Legursky,* 188 W.Va. 526, 425 S.E.2d 202 (1992.) The Board has asserted that Dr. Del Giorno has exhibited a pattern of practice that is not proper for a medical professional, an allegation that goes to the heart of his character. The testimony by the Respondent's peers, who were professionals in a position to observe his actions and know his reputation in the community, especially the medical community, was proper. The objection is overruled.

Hearsay: Dr. Del Giorno also objected to the testimony of the physicians from the Emergency Room of City Hospital, arguing that it was all based on hearsay. Pursuant to Rule 801 of the *W.Va. Rules of Evidence,* hearsay testimony is a statement, other than one made by the Declarant while testifying at the trial or hearing, offered to prove the truth of the matter asserted. Dr. Del Giorno asserts that because various persons who were treated by the physicians at City Hospital told said physicians that they were patients of Dr. Del Giorno, the subsequent testimony by the physicians about theses statements were hearsay and not admissible. While the statements by the patients would appear to be hearsay, they were not necessarily made or offered to prove the truth of the matter asserted, i.e., that Dr. Del Giorno had engaged in a pattern of unprofessional behavior. Moreover, under Rule 803 of the *W.Va. Rules of Evidence,* statements made for purposes of medical diagnosis or treatment and describing a patient's medical history are an exception to the hearsay rule. If the declarant's motive in making the statement was consistent with the purposes of

promoting treatment and the statement was reasonably relied upon by the physician in the treatment or diagnosis, the exception applies and the statement is not hearsay. *Atkins v. Conley,* 504 S.E. 2d 920 (W.Va. 1998). Since asking a patient who presents in the emergency room about his or her usual treating physician is a standard, if not mandated, practice in the medical field, required for treating the patient and coordinating with said physician, the statements of the patients to the witnesses that Dr. Del Giorno was their treating physician are not hearsay. The objection is overruled.

Sequestration of Witnesses: The Respondent argues that since all witnesses were required to be sequestered, the Board violated this provision when it gave the investigative report from Leslie Higginbotham, the Board's investigator, to the expert witness, Dr. Daniel Doyle. Rule 703 of the *W.Va. Rules of Evidence* provides that the facts or data in a particular case upon which an expert bases an opinion may be those make known to the expert at or before the hearing. An expert's opinion is based, in part on admissible facts or data presented prior to trial or upon inadmissible information that is reasonably relied upon by experts in that field. *Mayhorn v. Logan Medical Foundation,* 193 W.Va. 42, 454 S.E.2d 87 (1994); *Wilson v. Wilson,* 208 W.Va. 581, 542 S.E.2d 402 (2000). Dr. Doyle based his opinion, in part, on a review of the incidents noted in the investigative report, which was admissible. The report did not draw any conclusions; it merely stated the findings and facts of the investigator, and contained information upon which an expert could reasonably rely. The Board

also notes that the Respondent did not raise this objection at the hearing, and it should be considered waived. The objection is overruled.

ISSUES

Whether the Respondent violated the provisions of the West Virginia Medical Practice Act and Rules of the Board by:

a. Failing to practice medicine with that level of care, skill and treatment recognized by a reasonable, prudent physician engaged in the same or similar specialty as being acceptable under similar conditions or circumstances in violation of *W.Va. Code* §30-3-14(c)(17) and 11 CSR 1A §12.1(x);

b. Demonstrating professional incompetence in violation of *W.Va. Code* § 30-3-14(c)(20) and 11 CSR 1A §12.1(i);

c. Prescribing prescription drugs in an manner other than in good faith and in a therapeutic manner in accordance with accepted medical standards in violation of *W.Va. Code* § 30-3-14(c)(13), 11 CSR 1A §§12.1(e) and (v) and 11 CSR 1A §§12.2(a)(A), (B) and (D);

d. Engaging in unprofessional, unethical and dishonorable conduct of a character likely to harm the public, which said conduct had the effect of bringing the medical profession into disrepute in violation of *W.Va. Code* § 30-3-14(c)(17) and 11 CSR 1A §12.1(e) and (j) and §12.2.(d);

e. Failing to keep adequate written records justifying the course of his treatment in violation of *W.Va. Code* § 30-3-14(c)(11) and 11 CSR 1A §12.1(u); and/or

f. committing acts and/or a pattern of acts during the course of his medical practice which, under the attendant circumstances, are considered to be grossly incompetent, grossly ignorant and grossly negligent and/or committing malpractice in violation of *W.Va. Code* § 30-3-14(c)(17) and 11 CSR 1A §§ 12.1(e) and 12.2(c).

WITNESSES

Board Witnesses:

1. Leslie A. Higginbotham
2. Robert C. Knittle
3. Louis J. Del Giorno
4. David A. Potters
5. Daniel Doyle, M.D.
6. Daryl LaRusso, M.D.
7. Allen E. Meske, M.D.
8. Eric Glass, D.O.
9. John W. Ellis, M.D.
10. Phillip C. Von Dongen, M.D.
11. Brandt H. Williamson, M.D.

Respondent Witnesses:

1. Robert C. Knittle
2. Louis J. Del Giorno

EXHIBITS

Board Exhibits:

1. Deposition of Daryl M. LaRusso, M.D.
2. Deposition of Allen E. Meske, M.D.
3. Deposition of Bradley W. Mongold, M.D.
4. Deposition of Eric Glass, D.O.
5. Deposition of John W. Ellis, M.D.
6. Deposition of Philip C. Van Dongen, M.D.
7. Deposition of Brandt H. Williamson, M.D.
8. Subpoena to City Hospital for patient records
9. Subpoena to City Hospital for personnel file
10. Subpoena to City Hospital for 29 patient charts

11. Subpoena to City Hospital for chart of JP
12. Subpoena to Dr. Daryl M. LaRusso
13. Subpoena to Dr. Louis J. Del Giorno
14. Subpoena to Dr. Louis J. Del Giorno
15. Higginbotham investigative report
16. City Hospital Table of patients
17. Not Admitted
18. Medical records of Patient No. 1 (AB)
19. Medical records of Patient No. 2 (FF)
20. Medical records of Patient No. 3 (JB)
21. Medical records of Patient No. 4 (WJG)
22. Medical records of Patient No. 5 (DDH)
23. Medical records of Patient No. 6 (LL)
24. Medical records of Patient No. 7 (MM)
25. Medical records of Patient No. 8 (KSN)
26. Medical records of Patient No. 9 (PWH)
27. Medical records of Patient No. 10 (JDW)
28. Medical records of Patient No. 11 (DPB)
29. Medical records of Patient No. 12 (JMP)
30. Medical records of Patient No. 13 (SL)
31. Medical records of Patient No. 14 (BA)
32. Medical records of Patient No. 15 (SM)
33. Medical records of Patient No. 16 (JP)
34. Medical records of Patient No. 17 (VWG)
35. Medical records of Patient No. 18 (RC)
36. Medical records of Patient No. 19 (JH)
37. Medical records of Patient No. 20 (JH)
38. Medical records of Patient No. 21 (KS)
39. Medical records of Patient No. 22 (EC)
40. Medical records of Patient No. 23 (LP)
41. Medical records of Patient No. 24 (RS)
42. Medical records of Patient No. 25 (JBS)
43. Medical records of Patient No. 26 (DR)
44. Board of Pharmacy records of Patient No. 27 (KB)
45. Medical records of Patient No. 28 (SR)
46. Medical records of Patient No. 29 (HW)
47. Medical records of Patient No. 30 (KDF)
48. Medical records of Patient No. 31 (WW)
49. Del Giorno license renewal application
50. WV BOM Complaint File
51. WV BOM Complete Report of Licensee w/History
52. Daniel B. Doyle, M.D., Curriculum Vitae
53. Consultant Review Report
54. DEA Practitioner Guide
55. WV Board of Medicine Newsletter, January 2007
56. City Hospital Letter to Del Giorno, June 16, 2000

57. City Hospital Notice of Hearing, August 16, 2000

Respondent Exhibits:

1. Del Giorno Memo to Patients
2. Board of Pharmacy Report
3. Conversion chart
4. Perdue letter to Del Giorno, June 18, 2009
5. *Responsible Opiod Prescribing,* Scott Fishman
6. Board of Pharmacy Patient Profiles
7. WV Board of Medicine Newsletter, January 2005
8. Del Giorno letter to patient CE, May 29, 2007
9. Various patient letters, 6/27/05
10. Various patient letters, 8/29/05
11. Various patient letters, 11/22/04
12. List of discharged patients
13. List of patients seeking appointments
14. Drug conversion chart
15. List of patients treated for overdose, City Hospital
16. *Rx Review,* newsletter
17. Pain management contract
18. Complaint No. 09-81-R decision

Hearing Exhibits:

1. Letter to West Virginia Board of Osteopathy from Patricia S. Hofstra, counsel for Dr. Daryl LaRusso

INTRODUCTION

The undersigned Hearing Examiner has made the following findings of facts and has reached the following conclusions of law after a careful review of the record and the exhibits admitted into evidence, stipulations entered into by the parties, matters of which the undersigned took judicial notice during the proceedings, assessing the credibility of the witnesses, and weighing the evidence. To the extent that these findings of fact and conclusions of law are consistent with any proposed findings of fact and conclusions of law submitted by the parties, the same are adopted by the Hearing Examiner; conversely, to the

extent that the same are inconsistent with these findings and conclusions, they are rejected. To the extent that the testimony of any witness is not in accord with these findings and conclusions, such testimony is not credited. Any proposed finding of fact, conclusion of law or argument proposed and submitted by a party but omitted herein is deemed irrelevant or unnecessary to the determination of the material issues in this matter.

FINDINGS OF FACT

1. The Respondent, Louis John Del Giorno, M.D., was born in Brooklyn, New York. He was graduated *cum laude* from City College of New York and the University of Messina Medical School in Italy (1981.) He worked for one year as a surgical resident at Methodist Hospital in Brooklyn, New York, and completed a family practice residency in Hoboken, New Jersey (1985.) He practiced briefly in New York and later moved to Florida.
2. Dr. Del Giorno was recruited to West Virginia by City Hospital in Martinsburg. He was licensed to practice medicine in the State of West Virginia pursuant to License No. 16605, received from the West Virginia Board of Medicine in 1991. The Respondent works as a family practitioner in Martinsburg, West Virginia. He was board certified as a family practitioner from 1986 until 2002, when the certification expired. He has a DEA license for prescribing medications, but not for dispensing.
3. The Respondent has been licensed in the States of Florida (surrendered), Maryland (suspended), New Jersey (expired) and New York (revoked.) Dr. Del Giorno worked at City Hospital in Martinsburg until he lost his

privileges to practice there after he falsified a document regarding his malpractice insurance coverage.

4. In or about 1999 the Respondent took over the practice of a local neurologist in Martinsburg. He was concerned because the patients were receiving large volumes of opiods and other controlled substances that were not within the realm of dosages that he had been accustomed to seeing as a family physician. Since pain management was not within his realm of practice, Dr. Del Giorno called the West Virginia Board of Medicine for guidance and attempted to educate himself on this area through a review of the Board rules, information received from pharmaceutical companies and attendance at conferences and seminars.
5. In or about 2004 the Board received a complaint regarding the prescribing practices of Dr. Del Giorno. After investigation of the matter, the Board did not find any improper action on the part of the Respondent, but did suggest that he attend additional training. Consequently, the Respondent attended a pain management and substance abuse conference at Case Western University Medical School.
6. Daryl M. LaRusso, M.D., is a physician employed as the managing agent and medical director the Salutis Group, which consists of several physicians that provide emergency room medical services to City Hospital in Martinsburg. In December 2007 Dr. LaRusso sent a letter to Robert Knittle the Executive Director of the Board, stating that some of the physicians in his group had a general concern that Respondent's patients

they encountered in the emergency room seemed to have an inordinate amount of narcotic or benzodiazepine-like medication prescribed.

7. Consequently, the Board directed Leslie Higginbotham, its investigator, to review the allegations. Ms. Higginbotham is a Certified Medical Board Investigator, a member of the National Association of Drug Diversion Investigators and works with federal, state and county drug enforcement task forces. She is a registered user of the West Virginia Board of Pharmacy Controlled Substances Monitoring Program. Ms. Higginbotham has worked for the Board since 1993.
8. Ms. Higginbotham's investigation into the Del Giorno matter included reviewing medical records and other reports from the office of Dr. Del Giorno and City Hospital, interviewing witnesses, pulling and reviewing Board of Pharmacy reports Ms. Higginbotham completed her investigation, the results of which are reflected in Board Exhibit No. 18.
9. As a result of the investigation, the West Virginia Board of Medicine filed its Complaint and Notice of Hearing on July 24, 2009, alleging that the Respondent, Louis J. Del Giorno, had violated numerous provisions of the applicable statutes and administrative rules, and asserting that his medical license should be revoked. The Respondent filed his Answer on September 9, 2009. The parties then engaged in extensive discovery, which included the taking of numerous evidentiary depositions, an exchange of discovery, witness lists and anticipated exhibits.

10. The administrative hearing began on December 15, 2009, in the Board offices in Charleston, West Virginia. John A. W. Lohman appeared as counsel for the Board. The Respondent appeared *pro se.*

11. Leslie A. Higginbotham, the Investigator for the Board of Medicine, testified as to her investigation into this matter, subpoenas issued, reports received from the Board of Pharmacy and her methods of acquiring such information. The testimony of Ms. Higginbotham was credible and reliable.

12. Robert C. Knittle, Executive Director of the Board of Medicine, testified as to the record keeping, licensing and Complaint Committee procedures at the Board. He testified that the Complaint Committee had requested an investigation into the practices of Dr. Del Giorno and requested that he obtain an independent expert to review the matter. Mr. Knittle retained Dr. Daniel Doyle, a family practitioner, to perform a record review for the Board and render an opinion. He gave Dr. Doyle an outline or synopsis of the information available to the Complaint Committee to use as a basis for his review. The testimony of Mr. Knittle was credible and reliable.

13. The Executive Director and General Counsel for the West Virginia Board of Pharmacy, David Potters, Esq., testified about the Controlled Substance Monitoring Program within his office. The program is required by law, and is an on-line database where pharmacists and physicians transmit to the Board all dispensings of Schedule II through IV controlled substances. The information is electronically transmitted and housed in

the database, which can only be accessed by authorized or permitted individuals. Mr. Potters testified that on-line users of the system, including the Board of Medicine Investigator and approved physicians, may obtain information on controlled substance prescriptions. The records of the Board of Pharmacy can indicate the name of the prescribing physician, the name of the patient, the location of the pharmacy and identify the drugs that are prescribed and filled. Mr. Potters admitted that no system is perfect, and that the database is the product of information reported to it. Often a patient name is misspelled or an incorrect DEA number or National Drug Code is entered. The database also does not reflect prescriptions filled by patients in other states. However, for the most part he felt that the system was pretty accurate. The testimony of Mr. Potters was credible and reliable.

14. The Board presented expert testimony from Daniel Doyle, M.D. Dr. Doyle was graduated from the University of Notre Dame (1968) and from the Harvard Medical School (1974), completed his residency in family medicine at the University of Massachusetts, Wooster (1977), as well as a rotating internship at Cambridge Hospital, and began practicing in West Virginia in 1977. He is Board certified in family medicine and geriatrics. Dr. Doyle has been certified in family medicine since 1978 and in geriatrics since 1994. He practices with the New River Health Association in Fayette County, an organization that Dr. Doyle helped create. He has been the Medical Director of the Breathing Center/Black Lung Clinic since

1985. He also chairs the Chronic Pain Interdisciplinary Team, an internal group at New River that monitors pain management and improves the quality of care.

15. Dr. Doyle is an adjunct faculty member of the West Virginia University School of Medicine, the Marshall University School of Medicine and the West Virginia School of Osteopathic Medicine. He is a member of the American Academy on Communication and Health Care, the American Medical Directors Association and the American Geriatric Society. He is the Director of Medical Education Rivers and Bridges Consortium of the West Virginia Rural Health Education Partnership. He has received the Rural Physician of the Year Award (1996), the Governor's Outstanding Rural Health Practitioner Award (1996) and the Rural Health Practitioner of the Year Award from the National Rural Heath Association (1997).

16. Although he works mainly as a family practitioner, Dr. Doyle has vast experience with chronic pain management. He testified that because New River is a community health center with multiple physicians, physician assistants, nurse practitioners and a pharmacy on site, pain management is a big part of his practice. He has personal experience in treating patients who take opioids and other pain medications, and has treated patients who have overdosed. In addition to being the chair of the Chronic Pain Interdisciplinary Team at New River, he is the author of the Dysfunctional Use of Controlled Substances (DUCS) clinical screening tool developed by the clinic. The DUCS tool has been in place since 2000

at New River Health and is a screening tool that establishes standards for when a provider should be concerned about prescription use by a patient. Dr. Doyle has presented the tool at the West Virginia Pain Summit in 2005, to Cabin Creek Clinic (which has adopted the tool) and to the collaborative care workshop in Charleston in 2009. Without objection, Dr. Doyle was admitted at hearing as an expert in the areas of family medicine and pain management.

17. Dr. Doyle reviewed patient charts from Dr. Del Giorno's office, medical records of 18 patients from City Hospital and Board of Pharmacy ("BOP") reports on 35 patients. Dr. Doyle testified that he reviewed these records according to the standards of the West Virginia Code and Board of Medicine Legislative Rules. He reviewed the DEA web site, the Board requirements for prescribing controlled substances for chronic pain, and the Federation of State Medical Board's Guidelines.

18. Dr. Doyle also utilized the Fishman monograph regarding responsible opiate prescribing, a model presented by Dr. Schott Fishman at a training program presented by the Board and West Virginia University. Dr. Doyle testified that Fishman and the Board of Medicine identify seven areas for guiding a physician in the prescribing of opiates and treatment of chronic pain: effective patient evaluation, creating a treatment plan, informed consent and agreement, periodic review, referral on patient management, documentation and compliance with relevant law.

19. Dr. Doyle concluded that the practice of Dr. Del Giorno with respect to prescribing Opiates and controlled substances did not meet the guidelines and rules of the Board of Medicine and did not constitute prudent, competent practice in terms of prescribing controlled substances and Opiates. His findings were reflected in his report, Petitioner's Exhibit No. 53, which consisted of his cover report and 36 individual case summaries on patient records, as well as spreadsheet summaries.

20. Dr. Doyle testified that based on his review of the records he found nine areas of deficiencies in addition to sentinel events, which he identified as events demonstrating an unacceptable lapse of judgment and failure to practice acceptably even in isolation. He found that the Respondent was deficient in starting controlled substances without an effective patient evaluation. The Respondent's charts did not include any background records or sufficient documentation of the reason why the patient needed chronic pain medicine. There were almost never any urine drug screens at baseline. There was never a Board of Pharmacy query, notwithstanding the availability of online reporting and records from the BOP for the past four years. Dr. Doyle testified that there was no effort by Dr. Del Giorno to get local hospital records for his patients. Almost every patient was given a prescription for opiates or controlled substances at the initial visit. Opiates were started even when the patient admitted diversion or abuse of illicit substances, such as cocaine.

21. Dr. Doyle found the Respondent records showed numerous office visits by patients with very little care being rendered by Dr. Del Giorno. Many of Respondent's patients presented every 28 days and were being seen for a very brief visit, often with no physical exam or even a blood pressure reading recorded. There was a lack of periodic review such as a physical examination, a urine drug screening, a periodic BOP review or a discussion with the patient about other means of pain relief. There was not much documentation other than just having more and increasing amounts of medication prescribed.

22. Dr. Doyle testified that Respondent often prescribed very high doses of controlled substances, particularly opiates, on a routine basis. Dr. Doyle further testified that in some of Dr. Del Giorno's patient cases, there was enough medicine prescribed for five people to overdose and die. The higher the opiate dose, the greater the potential side effect of respiratory depression, which can be fatal.

23. Dr. Doyle testified to being "really worried" about Respondent's use of Methadone. In some patient cases, Dr. Del Giorno doubled the Methadone dose at one visit. Such a practice is particularly dangerous because an overdose of Methadone may not increase pain relief significantly, but may dramatically increase respiratory depression. Dr. Doyle testified that there is good evidence that increasing the dose of Methadone does not necessarily improve patient function. He noted that

Dr. Del Giorno's records did not document well the improved function of this group of patients, nor did they delineate functional goals.

24. Dr. Doyle testified that Respondent often used a "13 month year" in prescribing medications, which is a pattern whereby a patient is prescribed a 30-day supply of medication every 28 days. Consequently, the patient receives an additional month's worth of medication per year. Such a practice is particularly problematic where the monthly prescription quantities are 480 or higher because it provides the patient with extra pills that can be taken, diverted or sold. Dr. Doyle testified that this is a very dangerous practice in light of the unique danger of Methadone overdose.

25. Dr. Doyle testified that Respondent exhibited a serious failure to intervene. There were repeated instances in the records reviewed where a reasonably prudent physician should have recognized an abuse problem and stopped prescribing. However, the Respondent merely documented a problem with a patient and continued providing the controlled substances. Dr. Doyle noted examples in the files that should have caused the Respondent to intervene, including instances where patients used more medications than those prescribed by the Respondent; where people called the Respondent's office to report that drugs prescribed to his patients were being sold or abused; and where patients had positive drug screens. Notwithstanding these particular instances of drug abuse, the Respondent continued to prescribe controlled substances and made no attempt to intervene.

26. Dr. Doyle testified that the Respondent dismissed patients without a referral or a change in diagnosis. Once Dr. Del Giorno did decide to terminate the patient/physician relationship, he dismissed the patient through a telephone phone call or by sending a letter. Both practices put the burden on the patient to find another provider. Dr. Doyle testified that when a physician decides to stop prescribing opiates to a patient, the patient should be given a new diagnosis – addiction – and should be referred for addiction treatment.

27. Dr. Doyle testified that Respondent overused the drug Soma, which is a central-acting muscle relaxant, long known to be diverted and abused. Dr. Doyle testified that primary care physicians who treat pain should avoid this medication and in particular should not combine it with other centrally acting medications such as Benzodiazepines. Dr. Doyle testified that his review of the Respondent's records showed Soma being used a lot and in combination with multiple other central nervous system drugs. Dr. Doyle testified that he found cases wherein three or four central acting nervous system depressants were prescribed at one time, which is a risky practice increasing the risk of bad outcomes such as respiratory depression and death.

28. Dr. Doyle testified that the Respondent regularly prescribed high doses of controlled substances at a single visit. He also prescribed both "uppers" and "downers" to the same patient at the same time. The practice of combining multiple groups of controlled substances, some stimulating and

some depressing is questionable, particularly in light of the increasing doses and limited documentation in the chart.

29. Dr. Doyle testified that he was concerned that Respondent was treating both members of a couple. While such treatment could be perfectly legitimate, when one or both members of the couple demonstrate dysfunctional use of substances, the prescribing physician may be contributing to a patient problem and a community problem.

30. Dr. Doyle testified that he found a pattern of Dr. Del Giorno prescribing opiates and other controlled substances that was excessive, potentially harmful and, in some cases, actually harmful. He opined that such a pattern seriously violated the Board of Medicine rules. Dr. Doyle testified that he holds this opinion to a degree of high probability or reasonable certainty, to the clear and convincing standard and that it applied to each and every one of the patients on the patient key (patients one through thirty one) excepting patient number 13.

31. Dr. Doyle opined that the practice of the Respondent with respect to prescribing of opiates and controlled substances did not meet the guidelines and the rules of the Board of Medicine and did not meet prudent competent practice in terms of prescribing controlled substances and opiates. Dr. Doyle testified that this was based on a number of practices of Respondent that Dr. Doyle found very unacceptable, extremely dangerous and inappropriate. The testimony of Dr. Doyle was credible and reliable.

32. The Board submitted the evidentiary deposition of Daryl M. LaRusso, M.D., a physician employed as the managing agent and medical director for the Salutis Group, physicians that provide emergency room medical services to City Hospital. Dr. LaRusso testified that he sent the letter regarding the practices of Dr. Del Giorno to Mr. Knittle in December 2007. Dr. LaRusso testified that the physicians in the Salutis Group had a general concern that Respondent's patients seemed to have in inordinate amount of narcotic or benzodiazepine-like medication prescribed. Dr. LaRusso testified that his concern was based upon reports from his colleagues and his own personal observations in the emergency room at City Hospital. Dr. LaRusso testified that based upon his education and experience it appeared that here was a pattern of prescribing that seemed outside the standard of care. The testimony of Dr. LaRusso was reliable and credible.

33. The Board presented the evidentiary deposition of John W. Ellis, M.D., a physician with the Salutis Group. Dr. Ellis testified that he agreed with the sentiment behind sending the letter drafted by Dr. LaRusso to Mr. Knittle and that he had concerns about Dr. Del Giorno's practices He testified that he often saw patients with large doses of narcotics and benzodiazepine prescriptions. At the time the letter was sent by Dr. LaRusso, Dr. Ellis felt there were patients at risk and that Dr. Del Giorno was a danger to the public. The testimony of Dr. Ellis was credible and reliable.

34. The Board presented the evidentiary deposition of Allen E. Meske, M.D., a physician with the Salutis Group. He testified that he was aware of the decision to send the letter to the Board of Medicine, that he was consulted about the letter in advance, and that he had concerns about Dr. Del Giorno's practice. Dr. Meske testified that his general concern at the time was that Dr. Del Giorno was prescribing excessive amounts of controlled substances and that there was a potential for, and perhaps already had been, harm to some of those patients. Dr. Meske testified that he believed that Dr. Del Giorno is prescribing or has prescribed outside the standard of care and that he is a risk or danger to the community. The testimony of Dr. Meske was reliable and credible.

35. The Board presented the evidentiary deposition of Brandt H. Williamson, M.D., a physician with the Salutis Group. Dr. Williamston testified that it became clear to him, based on his personal observation of patients, that there were more and more patients presenting to the emergency room with large quantities of narcotics prescribed by the Respondent. Dr. Williamson testified that he agreed with sending the letter because of his concern for the community and his opinion that Dr. Del Giorno was prescribing excessively under the accepted prevailing medical standards. The testimony of Dr. Williamson was credible and reliable.

36. The Board presented the evidentiary deposition of Philip C. Van Dongen, M.D., a physician with the Salutis Group. He testified that he was at a meeting with Dr. LaRusso and others in which the Group discussed what

they had observed about the frequency of overdoses in patients of the Respondent as well as drug-seeking behavior from his patients. Dr. Van Dongen testified that he that sending a letter to the Board was the best thing to do because there were people being injured by what appeared to be a practice that was outside the norm. Dr. Van Dongen testified that the only reason he agreed to bring something before the Board of Medicine regarding the Respondent was his professional concern for the community. Dr. Van Dongen testified that based on what he knew in 2008, he believed Dr. Del Giorno to be a danger to the community and that he still has some concern. The testimony of Dr. Van Dongen was credible and reliable.

37. The Board submitted the evidentiary deposition of Eric Glass, D.O., a physician with the Salutis Group. He testified that based on patient experiences it was his opinion in 2008 that Respondent was not prescribing in good faith and in accordance with the accepted medical standards. The testimony of Dr. Glass was credible and reliable.

38. The Board submitted the evidentiary deposition of Bradley W. Mongold, M.D., a physician with the Salutis Group. He testified that he was in agreement with Dr. LaRusso sending the letter to the Board. He noted that members of the Salutis Group had discussed various issues they had with some of the Respondents patients they had seen. Some members of the Group felt quite strongly about the problems they encountered. Dr. Mongold testified that his opinion was not as strong as other members of

the Group, but that he had concerns, noticing a trend with Respondent's patients being on a number of narcotic and other types of medications. Dr. Mongold testified that he had concerns for the community. He has been in West Virginia since 1995 and is very much aware of an increasing problem with the diversion of prescription drugs. Dr. Mongold testified that the Eastern Panhandle region where he practices has a particularly difficult problem with prescription drug diversion. The testimony of Dr. Mongold was credible and reliable.

39. The Board submitted the medical records of multiple patients treated by Dr. Del Giorno. The records were reviewed by expert witness Dr. Daniel Doyle, who pointed out deficiencies on the part of the Respondent, including actions or inactions that were not within the realm of a reasonably prudent physician, that presented a danger to the patient or in other ways violated the statutes and rules relating to the practice of medicine in the state of West Virginia.

40. The Responded treated Patient No. 1 (AB) from June 2002 to September 2008. The patient had a history of severe mental illness and social dysfunction. Dr. Del Giorno prescribed Methadone and OxyContin, both Schedule II controlled substances, simultaneously to Patient No. 1. Dr. Del Giorno prescribed OxyContin for the patient with the request for "brand necessary," which means that a generic form of the drug should not be substituted.

a. In June 2003, Patient No. 1 was discharged from the practice of her prior physician for violation of her pain management agreement and was later seen in the City Hospital Emergency Room. At that time her urine drug screen was positive for barbiturates, which are controlled substances, and THC, the active ingredient in cannabis. Three days after this Emergency Room visit, Patient No. 1 was admitted for psychiatric care in Washington County Hospital. The psychiatric admission records indicated that the Patient had one son who was dysfunctional and another son who was an addict on Methadone maintenance. The records also indicated that Patient 1 suffered domestic abuse at the hands of her boyfriends.

b. Dr. Del Giorno did not conduct urine drug screens or pill counts with Patient No. 1 after 2003. From January 25, 2008, until September 2008, Dr. Del Giorno prescribed to her 720 Methadone 10 mg tablets every 28 days, which reflects the "13 month year" pattern.

41. The Respondent treated Patient No.2 (FF) from May 2005 to January 2007. Patient No. 2 was diagnosed with depression, with a history of having a motor vehicle accident. Despite involvement of family members with the care of Patient No. 2, the Respondent was not aware of the fact that Patient No. 2 had lung cancer and multiple hospital admissions.

a. At the time of Patient No. 2's final visit with Respondent, Patient No. 2 was receiving OxyContin 40mg three times per day in a "13 month year" pattern. Dr. Del Giorno increased Patient No. 2's

opiate analgesics morphine equivalent daily dose (MEDD) excessively in too short a period of time. The Respondent did not refer Patient No. 2 to a mental health professional, did not conduct pill counts and failed to give Patient No. 2 a urine drug screen.

42. The Respondent treated Patient No. 3 (JB) from February 2007 to August 2008. At the initial visit, Patient No. 3 presented an expired driver's license and admitted to cocaine use and opiate diversion. The Respondent noted that the patient had some drug use, but nevertheless prescribed opiates to her anyway. Patient No. 3 later presented to City Hospital with a drug overdose. After a urine drug screening was returned positive for cocaine, Respondent failed to stop or taper opiates for Patient No. 3. Respondent failed to refer Patient No. 3 for substance abuse therapy.

43. The Respondent treated Patient No. 4 (WJG) from November 2006 to April 2008. At Patient No. 4's initial visit, Respondent noted that the patient's clinical picture was not consistent with the MRI or x-ray reports. Respondent proceeded to prescribe Oxycodone and Xanax to Patient No. 4 at this visit. Respondent prescribed excess opiates to Patient No.4 and provided him with new prescriptions in too short a period of time.

    a. Despite referrals being made to an orthopedist and physical therapist, the Respondent's medical file for Patient No. 4 contains no reports from these providers. Patient No. 4 was treated at the City Hospital Emergency Room on May 11, 2007, at which time

Patient No. 4 admitted to intravenous heroin abuse. Patient No. 4 was later treated at the City Hospital Emergency Room on July 25, 2007, for heroin overdose. Respondent failed to obtain records regarding Patient No. 4 from City Hospital, the consulting physician and the physical therapist.

b. Respondent continued for seventeen (17) months to prescribe OxyContin to Patient No. 4, a heroin addict. Upon realizing the true nature of his patient's diagnosis – addiction – Dr. Del Giorno dismissed Patient No. 4 without advice to the patient regarding appropriate treatment.

44. The Respondent treated Patient No. 5 (DH) from October 2007 through June 2008. The medical records of Patient No. 5 include numerous signs of drug abuse, including a report by the patient that she had lost her OxyContin and visits to City Hospital for overdoses of drugs that Dr. Del Giorno had not prescribed. Nevertheless, the Respondent prescribed excessive quantities of opiates to Patient No. 5 at shorter than 30 day intervals. He ignored direct advice from Patient No. 5's psychiatrist to avoid prescribing opiates for her. Respondent's records of treatment of Patient No. 5 fail to indicate any repeat urine drug screening, pill counts, or Board of Pharmacy review hospitalizations for drug overdose.

45. The Respondent treated Patient No. 6 (LL) from June 2004 to July 2006. Patient No. 6 was illiterate and had a history of heroin addiction, past alcohol abuse, repeated injuries and a wound of his left hand. The

Respondent prescribed numerous controlled substances over the course of his care of Patient No. 6. However, he did not obtain a urine drug screening from Patient No. 6 nor did he conduct pill counts. The Respondent did not obtain any records regarding Patient No. 6's previous care for the first five (5) months of 2004.

46. The Respondent treated Patient No. 7 (MM) from April, 2005 to March 2006. The patient presented with a history of alcoholism and drug abuse. At the initial visit, Respondent prescribed Xanax, a Schedule IV controlled substance and increased the dosages instead of reducing them. The Respondent began prescribing opiates to Patient No. 7 on August 12, 2005. The Respondent then obtained psychiatric records pertaining to Patient No. 7 that indicated alcoholism and drugs abuse. Although Dr. Del Giorno noted in the file that he should decrease opiate use by Patient No. 7, he continued to prescribe opiates and actually increased the amount/dosage provided. Respondent did not intervene to address Patient No. 7's addictions, did not conduct pill counts and did not require a urine drug screening. Respondent's chart does not document any care coordination with mental health providers for Patient No. 7. On March, 11, 2006, Patient No. 7 was admitted to City Hospital for overdose of Lortab and Xanax, both controlled substances.

47. The Respondent treated Patient No. 8 (KSN) from July 12, 2001, to June 26, 2006. Patient No. 8 had significant indicators of substance abuse and diversion, including prior use of opiates and Methadone, repeated motor

vehicle accidents and a urine drug screen that was positive for marijuana. Respondent prescribed inordinately large quantities of controlled substances to Patient No. 8, including 360 Methadone tablets per month. Dr. Del Giorno eventually discharged the patient from his practice.

48. The Respondent treated Patient No. 9 (PW) from January 30, 2007, to April 30, 2007. The patient presented with complaints of anxiety and admitted to purchasing Xanax and Valium on the street. The Respondent prescribed an anti-depressant and Xanax, a scheduled controlled substance at the initial visit and at follow up visits. Patient No. 9 had significant indicators suggesting abuse and/or diversion, including admitting that she bought prescription drugs on the street, running out of medicine one to two weeks from her initial visit, and having a urine drug screen read positive for Methadone and benzodiazepines, scheduled controlled substances. The medical records also reflect that between the second and third visit by Patient No. 9, Dr. Del Giorno's office received an anonymous phone call alleging that Patient No. 9 was selling Xanax to children. After Patient No. 9 presented at the Emergency Room wanting IV opiates and had a urine drug screen positive for medications that he did not prescribe, the Respondent stopped prescribing medications for her.

49. The Respondent treated Patient No. 10 (JDW) from November 17, 2005, to April 4, 2008. Patient No. 10 had a history of a broken hand and alcohol abuse and fell within the age range indicative of a risk for abuse and/or diversion. Notwithstanding this risk, Respondent did not conduct a

urine drug screening, did not conduct pill counts and did not verify information from other sources regarding Patient No. 10. Respondent prescribed steadily increasing dosages of opioids for Patient No. 10 in a "13 month year" pattern.

a. After Patient No. 10 returned to Respondent's practice from an eleven (11) month absence, Respondent resumed prescribing opiods without a drug screening. He did not check the patient's records or history with the Board of Pharmacy and did not verify Patient No. 10's care and/or whereabouts in his absence from the Respondent's practice.

b. On April 10, 2008, Patient No. 10 was seen at City Hospital Emergency Department for drug overdose. He tested positive for heroin and cocaine, and admitted to I.V. heroin use and "recreational OxyContin use."

50. The Respondent treated Patient No. 11 (DB) from August 18, 2003, to February 6, 2007. Patient No. 11 presented with a history of chronic back pain and back surgery, dysfunctional use of opiates, including concurrent alcohol use, increasing use of opiates, multiple injuries and hospital admissions. Nevertheless, the Respondent prescribed OxyContin 40mg, 180 tablets every month to Patient No. 11. On July 14, 2006, the Respondent gave Patient No. 11 a prescription for OxyContin 40 mg, 180 pills. Four (4) days later on July 20, 2006, Patient 11 presented to the Emergency Department at City Hospital stating that she was "out of

OxyContin." As of January 9, 2007, Patient No. 11 was requesting and receiving prescriptions for brand necessary OxyContin from the Respondent on a "13-month year" basis.

51. The Respondent treated Patient No. 12 (JMP) from February 10, 2005, to September 4, 2008. During that period Patient No. 12 reported a significant number of serious social stressors, including a 14-month absence from the Respondent's practice, incarceration of her husband, head lice, eviction, and an alleged loss of medications in a house fire. She also exhibited a number of indicators suggesting alcoholism, including multiple accidents, various social stressors, uncontrolled blood pressure and elevated liver function tests.

    a. For approximately three and one half years after the initial visit, Patient No. 12 was seen every 27-30 days. The Respondent generally prescribed for her Oxycodone, a scheduled controlled substance. He later added Soma, a habituating substance, Sinequan, a tricyclic antidepressant, Xanax and Percocet, a controlled substance. During this period Respondent treated Patient No. 12's hypertension, but did not perform any additional work-up. Patient No. 12 was absent from Respondent's practice for over a year, returning on August 7, 2007. Respondent did not verify his patient's whereabouts during that time, nor did he perform a urine drug screen. During her last office visit with Respondent on September 4, 2008, the Respondent prescribed Percocet 10, 120

tablets. Two days later, Patient No. 12 presented at City Hospital Emergency Room, dead on arrival from a fatal drug overdose.

b. During his treatment of Patient No. 12, Respondent typically did not perform a physical exam, despite continuing evidence of uncontrolled hypertension. Respondent simply prescribed medication without working up the condition. The Respondent followed a "13 month year" prescribing pattern for Patient No. 12 and performed only one urine drug screening on August 30, 2005. Respondent did not conduct pill counts and did not request a Board of Pharmacy report during his treatment of Patient No. 12.

52. The Respondent treated Patient No. 13 (SL) from November, 25, 1996, to June 12, 2007. Patient No. 13 was a young person with a serious back injury who had been treated with prescriptive medications for over ten years. In treating Patient No. 13, Respondent prescribed increasing dosages of opiates and prescribed OxyContin and Methadone in combination, which increased the risk of addiction without increasing the benefit of the drug. The records reflect that the Respondent did not ever require a urine drug screening.

53. The Respondent treated Patient No. 14 (BA) from March 7, 2000 to December 13, 2007. The patient had a history of stomach and intestinal problems and depression. During that period the Respondent prescribed numerous controlled substances including Hydrocodone, Xanax and Soma simultaneously. He also started and restarted controlled

medications after long gaps in care and without performing a records review or requiring a urine drug screening. Dr. Del Giorno treated many of Patient No. 14's medication side effects with more medications.

a. Patient No. 14 exhibited indicators of abuse and/or diversion. He reported taking of more Hydrocodone than prescribed, ran out of opiates regularly and often requested more. There were long gaps in his care and treatment by the Respondent. During his treatment of Patient No. 14, Respondent followed a 13 month year prescribing pattern.

b. Patient No. 14 had a history of psychiatric diagnoses of depression and social anxiety with escalating symptoms. During his treatment of Patient No. 14, Respondent prescribed Soma in combination with Xanax. Despite Patient No. 14's escalating mental health and depression symptoms, Respondent never made a mental health referral for Patient No. 14. Many of Respondent's visits with Patient No.14 did not include a physical exam and often failed to note vital signs.

c. In 2002 and 2003 Patient No. 14 developed severe GI symptoms. A hospital consultant linked the symptoms to Respondent's prescribing. Respondent temporarily halted the prescriptions, only to later resume the same prescribing pattern with Patient No. 14. On October 2, 2004, Respondent prescribed Dilaudid, a Schedule II controlled substance, to Patient No. 14, despite being

contraindicated on gastrointestinal, mental health and addiction grounds.

d. Notwithstanding Patient No. 14's use of more Hydrocodone than prescribed, the Respondent failed to conduct pill counts, urine drug screenings or run any form of intervention. Rather, Respondent increased Patient No.14's prescriptions. On November 29, 2007, Patient No. 14 presented at City Hospital Emergency Room with a drug overdose and suicide attempt. The following month the Respondent terminated the patient-physician relationship with Patient No. 14. He immediately discharged Patient No. 14 with an abrupt cessation of care without advice to the patient regarding appropriate treatment or referral for addiction treatment.

54. The Respondent treated Patient No. 15 (SM) from March 12, 2004 to October 8, 2007. The patient presented with back pain and had a history of psychiatric problems and possible alcoholism. During his treatment of Patient No. 15, Respondent prescribed controlled substances in increasing dosages and volumes. During the last two years of care with Respondent Patient No. 15 received prescriptions for Methadone 10 mg every four hours, #180 per month. Respondent did not conduct pill counts or require urine drug screenings of Patient No. 15. Respondent's records do not justify why the Methadone was prescribed.

a. On December 14, 2006, Patient No. 15 presented to City Hospital with Methadone overdose. The City Hospital records indicate that

a copy of the records form this visit was sent to the Respondent. Patient No. 15's monthly visits with Respondent continued after the hospital admission without any mention of the Methadone overdose in his chart. On July 23, 2007, Patient No. 15 was admitted to City Hospital with psychosis and probable alcoholism. Respondent did not intervene with Patient 15 after the hospital admissions.

55. The Respondent treated Patient No. 16 (JP) from October 26, 2007, to August 7, 2008. Prior to obtaining treatment from Respondent, Patient 16 had been admitted to the City Hospital psychiatric unit after an emergency room visit for an overdose of Darvocet, Tramadol and alcohol. Nevertheless, the Respondent prescribed opiates to Patient 16 at the initial visit. On April 11, 2008, Patient 16 complained of leg cramps at bedtime and the Respondent prescribed Soma, Percocet and Lyrica. The notes for the visit of July 14, 2008, state that Patient 16 "went on a drinking binge and apparently fell down during this episode." The noted that Patient 16 was seeing her previous psychotherapist. Respondent started prescribing opiates to Patient No. 16 without running a Board of Pharmacy report and without requiring a urine drug screening. Notwithstanding clear indications of an abuse of prescriptions and alcohol, the Respondent did not run any interventions for Patient No. 16.

56. The Respondent treated Patient No. 17 (VWG) from August 30, 2004, to October 16, 2006. Dr. Del Giorno diagnosed spinal disease, although there was no objective evidence for the same. The Respondent obtained

a lumbar MRI on the second visit, which was normal. Respondent started prescribing Oxycodone and Percocet to Patient 17 as of the initial visit and increased the doses steadily over the next 14 months. There is no indication in Respondent's chart for Patient No. 17 that Respondent ever conducted a urine drug screen on Patient No. 17 or that he ever obtained any records regarding Patient No. 17's previous care.

a. Patient No. 17 was absent from Dr. Del Giorno's care for nine (9) months. Upon his return, the Responded diagnosed depression, noting a history of unemployment and two (2) emergency room visits. The Respondent prescribed Hydrocodone, Xanax and Naprosyn. The medical chart for Patient No. 17 does not reflect that the Respondent ever conducted a urine drug screening, nor does it contain a history of medical care that Patient 17 received during the nine-month absence. The Respondent's chart does not reflect any Board of Pharmacy report on Patient No. 17, nor is there any mental health referral for Patient No. 17's depression.

b. On August 10, 2006, Patient No. 17 was seen in the City Hospital Emergency Room for an apparent opiate overdose. After that, Patient No. 17 had three (3) additional visits with Respondent over the next three (3) months. The Respondent prescribed OxyContin at each visit. The office notes for Patient No. 17's visit on October 16, 2006, stated "patient doing very well, no new complaints. Adjusting well to new job . . . better with increased Rx." The next

chart entry in for Patient No. 17 is on October 24, 2006, which states, "Have been informed that the patient committed suicide."

57. The Respondent treated Patient No. 18 (RC) from May 22, 2003, to June 13, 2006. Respondent began seeing Patient No. 18 on a monthly basis. He initially prescribed Soma, but changed the prescription to Xanax on the third visit. By the fourth visit with Patient No. 18, Respondent increased the Xanax prescription and added prescriptions for Fioricet, a scheduled controlled substance, and Lexapro. On April 30, 2006, Patient No. 18 was seen at City Hospital Emergency Room for Xanax overdose related to depression. The records from City Hospital visit indicate a concern with Patient No. 18 having mixed alcoholism and benzodiazepine use. After Patient No. 18's overdose, Respondent failed to intervene with Patient No. 18 with discontinuation of Benzodiazepines and mandatory psychiatric or substance abuse consultation.

58. The Respondent treated Patient No. 19 (JH) from November 5, 2007 to August 18, 2008. She originally presented with complaints of chronic knee pain and neck and back pain secondary to an automobile accident. Patient No. 19 presented Respondent with a Pennsylvania driver's license but listed a West Virginia address. Respondent did not obtain City Hospital records on Patient No. 19 that reflected prior admissions for drug overdoses.

    a. Patient No. 19's initial MRI study was normal and inconsistent with the symptoms reported by Patient No. 19. Nevertheless, the

Respondent gave Patient No. 19 a prescription for Percocet. Respondent continued prescribing Percocet to Patient No. 19 for the next 10 months. At Patient No. 19's request Respondent changed the Percocet prescription from 10mg q.i.d. to 5mg 2 q.i.d. resulting in Patient No. 19 receiving prescriptions for 240 tablets per month.

b. Patient No. 19 delayed orthopedic consults, further imaging and bone scans, but the Respondent continued prescribing large doses of Oxycodone to her. In July 2008, Respondent's office documented telephone calls from the boyfriend and mother of Patient No. 19 stating that Patient No. 19 was selling her medication.

59. The Respondent treated Patient No. 20 (JH) from September 13, 2002 to June 26, 2008. Patient 20 presented with multiple medical problems and multiple medications. Patient No. 20 had been receiving care at the VA hospital, including psychiatric care. At Patient No. 20's second visit with Dr. Del Giorno, the Respondent prescribed OxyContin 40 b.i.d., which replaced a previous physician's prescriptions of OxyContin 20 b.i.d. and Lorcet. Patient No. 20 continued with regular visits to Respondent, who steadily increased the dosage of opiate prescriptions. By the end of 2007, Patient No. 20 was receiving OxyContin (brand necessary) 80 mg 2 q 4 hours #360 per month and taking it concurrently with Dilaudid, 4 mg # 60 per month.

a. During the period of treatment with Respondent, Patient No. 20 was admitted to the Veterans' Administration hospital for congestive heart failure, diabetes, and pancreatitis. He had complicated medical problems and the medical records do not indicate that he benefited from the continuous escalating doses of opiates prescribed by Dr. Del Giorno. The Respondent's records for Patient No. 20 reflect little coordination of care with the VA physicians.

60. Respondent treated Patient No. 21 (KS) from March 1, 2004, to September 4, 2008. Patient No. 21 had a history of a motor vehicle accident in 1990 with significant injury and was on very high dose chronic opiates when he came under Respondent's care. At Patient No. 21's first visit with Respondent, he presented with an injury to his left knee after a fall. Respondent prescribed Percocet.

a. On July 20, 2004 Respondent prescribed to Patient No. 21 Methadone 10, #3 q 4 hours 470 tablets a month. Respondent notes on this date described depression and stated "patient never had urine screen."

b. On January 25, 2005, Patient No. 21 presented with facial trauma from an alleged attack in which his wallet was stolen. Respondent prescribed additional Methadone.

c. By the end of 2006 Patient No. 21 was receiving Methadone 10 mg, #4 tabs 5 times daily (200 mg per day), 600 tablets per month. This

level of prescribing continued through 2007 and through the final visit with Respondent on September 4, 2008.

d. Over the last two years of treatment Patient No. 21 received over 7000 Methadone tablets per year. Despite the huge volume of opiates being prescribed, Respondent did not conduct pill counts or urine drug screenings, nor did he request a Board of Pharmacy report for Patient No. 21.

61. Respondent treated Patient No. 22 (EC) between January 19, 2004 and September 15, 2008. During the treatment of Patient No. 22 the Respondent prescribed a number of different controlled substances, including Methadone, Percocet and Klonopin. In January 2007 a pharmacist phoned Respondent noting that Patient No. 22 had attempted to fill his prescription of Methadone earlier than he should have. By 2008 Respondent was prescribing to Patient No. 22 480 Methadone tablets every 21 to 25 days. In September 2008 Patient No. 22 advised the Respondent that he was moving to New Mexico, and Dr. Del Giorno prescribed 640 pills for him. Upon his return to Dr. Del Giorno's care, Patient No. 22 explained that he had been incarcerated for grand larceny. During the period of treatment by Respondent of Patient No. 22, Respondent followed a "13-month year" prescribing pattern, did not conduct a urine drug screening, did not request Board of Pharmacy reviews or reports, and did not seek third party collaboration in relation to the treatment of Patient No. 22.

62. The Respondent treated Patient No. 23 (LP) from October 17, 1994 to September 23, 2008. During the period of treatment the Respondent prescribed a number of controlled substances to Patient No. 23, including Oxycodone, OxyContin and Dilaudid, in escalating amounts. Patient No. 23 had conversion disorder and did not have a verified pain diagnosis until an auto accident in 2006. The Respondent did not conduct pill counts, request a urine drug screening or seek Board of Pharmacy reviews in relation to Patient No. 23.

63. The Respondent treated Patient No. 24 (RS) from October 28, 2005, until May 8, 2006. The patient had a history of chronic neck pain, COPD and depression. During the period the Respondent treated Patient No. 24, Dr. Del Giorno prescribed Soma and controlled substances, including Oxycodone and Roxicodone. The Respondent followed an accelerated prescribing pattern with Patient No. 24, allowing for the dispensing of more medication than required for the dosing prescribed within the time interval between appointments. During the March 28, 2006, office visit, Dr. Del Giorno noted that the patient should be referred to a pain management clinic, but he still continued the prescribed medications. On April 6, 2006, the Respondent again wrote prescriptions for Soma. On the May 8, 2006, office visit, the Respondent again noted that Patient No. 24 had discrepancies in his stories; that he would give him prescriptions for one more month and that the patient needed to get sent to a pain management in Winchester. He again prescribed Roxicodone and Soma, but noted that

"this is his last visit here." On July 12, 2006, Patient No. 24 was admitted to City Hospital for a drug overdose and suicide attempt. On October 9, 2006, Patient No. 24 was again admitted to City Hospital with a drug overdose. At the time he tested positive for benzodiazepines, marijuana and opiates.

64. The Respondent treated Patient No. 25 (JBS) from February 24, 2004, to August 29, 2008. Patient No. 25 described a medical history of neck and back pain with severe headaches and a prior motor vehicle accident. The intake form reflected that the patient had sought care from health care providers 12-15 times in the past year for her pain problems. Nevertheless, the Respondent prescribed opiates for Patient No. 25 at the initial visit without conducting a review of past medical records and without conducting a baseline urine drug screening.

    a. Over the period of time that the Respondent treated Patient No. 25, he prescribed Soma and a number of controlled substances to Patient No. 25, including Dilaudid, Klonopin, Neurontin, Xanax, Methadone, Kadian and Avinza. The Respondent over-prescribed opiates to Patient No. 25 in January 2006 without consideration of a December 2005 hospital admission.

    b. In March 2006 Respondent's office received an anonymous phone call indicating that Patient No. 25 was selling her medications. The Respondent ordered a urine drug screen three weeks later, which showed the absence of all prescribed drugs. Respondent stopped

Kadian and Dilaudid, but immediately started Patient No. 25 on Methadone and Xanax. This "intervention" substituted one opiate for another and was not followed up by the Respondent in the next two years. The Respondent also prescribed a large number of central nervous system medications with conflicting effects.

65. The Respondent treated Patient No. 26 (DR) from March 29, 2004, to August 14, 2008. Patient No. 26 complained of headaches with loss of vision due to a work accident in 1996. Respondent began prescribing opiates at the initial visit, without first obtaining copies of previous medical records and without requiring a baseline urine drug screen. During the time the Respondent treated Patient No. 26, he prescribed a number of controlled substances to Patient No. 26, including Hydrocodone, Xanax, Lorcet and OxyContin. By the final visit with Respondent, Patient No. 26 was receiving prescriptions for OxyContin 20 mg #90 month, Xanax 1 mg #120 per month. The Respondent did not ever require a urine drug screen, did not request a Board of Pharmacy Review for this patient and did not conduct pill counts.

66. The Respondent treated Patient No. 27 (KB) from January 2008 until March 25, 2008. During this period the Respondent gave Patient No. 27 repeated prescriptions for Soma and Oxycodone. In a single 30-day period the Respondent prescribed for Patient No. 27 395 Soma tablets in eight (8) separate prescriptions. The Board of Pharmacy Review for

Patient No. 27 reflects a long prior history of requesting and receiving similar medications.

67. Respondent treated Patient No. 28 (SR) from October 12, 2004, to July 13, 2006. The patient reported numerous falls and constant back pain. The Respondent prescribed 120 Hydrocodone pills per month while Patient No. 28 was also sometimes taking birth control pills. On October 21, 2004, Respondent prescribed Ortho Tricylen for contraception and was managing Patient No. 28's gynecological care and was therefore aware that Patient No. 28 was a female in child-bearing years and potentially sexually active. Respondent failed to conduct regular exams of Patient No. 28 and failed to recognize that Patient No. 28 had become pregnant. Respondent continued to prescribe opiates to Patient No. 28 into the six month of pregnancy. When Patient No. 28 was 18 weeks pregnant she had an office visit with the Respondent. At that time the Respondent prescribed Elavil and Hydrocodone for Patient No. 28, but the chart does not reflect that any vital signs were taken and there was no documented physical exam.

68. The Respondent treated Patient No. 29 (SR) from September 23, 2003, to August 19, 2008. Patient No. 29 was born in 1923. During this period the Respondent prescribed Wellbutrin and a number of controlled substances for Patient No. 29, including Lortab, OxyContin and brand necessary Xanax. During the treatment of Patient No. 29 Respondent failed to conduct pill counts, failed to require a urine drug screen and failed to

request a Board of Pharmacy report for Patient No. 29. Dr. Del Giorno also followed a "13-month year" pattern of prescribing with Patient No. 29.

69. The Respondent treated Patient No. 30 (KDF) from October 3, 2003, to September 15, 2008. She presented with complaints of panic attacks. During the initial visit, the Respondent provided a prescription for Oxycodone to Patient No. 30. On October 16, 2003, Respondent noted that Patient No. 30 went to the emergency room and had a positive urine drug screen for methamphetamines, cocaine and barbiturates. Respondent's plan was to obtain a urinalysis and if "clean" consider the patient for Methadone treatment. Respondent's chart does not reflect the result of any such follow up urinalysis or screen.

    a. On May 5, 2006, Respondent received a call from Patient 30's father indicating that Patient No. 30 was seeing a physician in Pennsylvania. Random drug screens showed no evidence of Methadone or Xanax in the patient's urine. During the period of treatment of Patient No. 30, Respondent failed to conduct pill counts and failed to request a Board of Pharmacy review.

    b. Patient No. 30's urine drug screen from Jefferson Memorial Hospital in October 2003 included positive results for street drugs including methamphetamine and cocaine. In August 2004, Patient No. 30 had a motor vehicle accident wherein the patient "ran into back of other car." Despite previous substance abuse and multiple indicators for potential abuse and/or diversion, Respondent was

providing prescriptions to Patient No. 30 for 480 tablets of Methadone a month.

70. Respondent treated Patient No. 31 (WW) from June 19, 2001, to August 26, 2008. The patient presented with a history of excision of a herniated back disc on December 20, 2000. Despite having an excellent surgical outcome, Patient No. 31 received from the Respondent prescriptions for escalating opiate doses for a period of approximately six years. The Respondent prescribed Soma and multiple controlled substances, including Lorcet, Dilaudid, Methadone, Tylox, and Valium. By August 2008, Respondent was providing Patient No. 31 prescriptions for 480 Methadone tablets a month. Respondent failed to conduct pill counts or request Board of Pharmacy reports for Patient No. 31. He also followed a "13-month year" prescribing pattern with Patient No. 31. Patient No. 31 was incarcerated seven (7) times through 2004, four during Patient No. 31's treatment with Dr. Del Giorno. Six of the periods of incarceration were for driving on a suspended license and one was for possession of marijuana. Respondent failed to recognize these indicators of potential abuse and/or diversion.

71. Dr. Daniel Doyle, the Board's expert witness, testified as to Patients No. 1 through No. 31, excepting Patient No. 13. He noted that 20 were male, 16 were female; that ten of the patients were born after 1976; 18 of the 36 patients had been admitted to City Hospital Emergency Room; eight had evidence of addiction, such as heroin or cocaine use; and 17 of the

patients had a history of overdoses, as documented by the Emergency Room records.

72. Dr. Doyle found that the Respondent, Dr. Del Giorno, had good medical knowledge and organization. The Respondent utilized opiate agreements, attempted to reflect new guidelines and current best practices and obtained additional pain management training at Case Western Reserve. He also testified that the Respondent did not consistently request medical records of his patients from other treating physicians, which is a safeguard and good medical practice in treating persons with opiates.

73. Dr. Doyle found a pattern and practice on the part of the Respondent that raised a concern about incompetence and inappropriate practice. He pinpointed nine (9) areas that summarized the pattern and problems that he found. The first area of concern was that the Respondent started prescribing controlled substances without conducting an effective patient evaluation, such as obtaining background records, sufficient documentation of the reason for chronic pain medicine, obtaining baseline drug screenings and obtaining Board of Pharmacy records. He also failed to routinely get local hospital records for his patients; routinely prescribed opiates or other controlled substances at the initial office visit without a follow-up; had many visits with his patients, but rendered very little care, not even a blood pressure reading.

74. Dr. Doyle found that the Respondent prescribed very high doses of controlled substances, especially as compared to other physicians in the

area. He also consistently engaged in the "13-month year" practice, which resulted in patients getting a 30-day supply of pills every 28 days. Dr. Doyle found that the Respondent demonstrated a serious failure to intervene with patients who were obviously misusing or diverting their prescriptions for controlled substances. Dr. Doyle found repeated instances in the patient medical records where a reasonable, prudent physician should have stopped prescribing. The fact that Dr. Del Giorno terminated the physician/patient relationship with some of his patients did not negate the seriousness of the often extreme instances where he should have stopped prescribing medications or treating the patient.

75. Dr. Doyle opined that the Respondent often dismissed a patient without referral. He often dismissed a patient with a telephone call or letter, which put the burden on the patient. Dr. Doyle stated that the patient should have been given a new diagnosis of addiction and properly referred for addiction treatment. He agreed with an article from the American Academy of Family Physicians that it is not acceptable to simply dismiss a patient from the practice and let him or her deal with addiction elsewhere.

76. Dr. Doyle had grave concerns about Dr. Del Giorno prescribing an excessive amount of Soma, a central acting muscle relaxant that is well-known for being abused and diverted. Dr. Doyle opined that it was risky and imprudent to prescribe Soma, especially in combination with multiple other central nervous system depressant drugs, opiates, benzodiazepines or alcohol.

77. Another area of concern for Dr. Doyle was the fact that the medical records revealed many single visits on which the Respondent prescribed high doses of medications. His review of the Board of Pharmacy logs showed that many patients would present at the Respondent's office, get a large dose of opiate medication and not be seen again. Dr. Doyle also found the Respondent's practice of prescribing uppers and downers together disturbing. This practice often leads to a dysfunctional use of substances.

78. Dr. Doyle opined that the Respondent's pattern of prescribing opiates and other controlled substances was excessive, potentially harmful and, in some cases, actually harmful. He opined that this pattern seriously violates both the Board of Medicine's Rule and the Drug Enforcement Agency's standards.

79. Based upon his review of the medical records of each patient, Dr. Doyle opined that the Respondent's care was below the level of care, skill, and treatment which is recognized by a reasonable and prudent physician engaged in the same or similar specialty as being acceptable under similar conditions or circumstances in violation of 11 CSR 1A 12.1(x).

80. Dr. Doyle further testified that in his opinion in his treatment of Patients No. 1 through 31 (excepting Patient No. 13) the Respondent violated the Board of Medicine Rules 11 CSR 1A and the provisions of *W.Va. Code* § 30-3-14(c)(17).

81. Dr. Doyle testified that in his opinion the Respondent, in his treatment of Patients No. 1 through No. 31, excepting Patient No. 13, had demonstrated professional incompetence and was in violation of *W.Va. Code* § 30-3-14(c)(20).

82. The Board's expert witness testified that in his opinion the Respondent, in his treatment of Patients No. 1 through No. 31, excepting Patient No. 13, had prescribed, dispensed, administered or prepared a prescription drug, including any controlled substance, other than in good faith and in a therapeutic manner in accordance with accepted medical standards and was in violation of *W.Va. Code* § 30-3(c)(13).

83. The Board's expert witness testified that in his opinion the Respondent, in his treatment of Patients No. 1 through No. 31, excepting Patient No. 13, demonstrated a lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients, and was in violation of 11 CSR 1A 12.1(i).

84. The Board's expert witness testified that in his opinion the Respondent, in his treatment of Patients No. 1 through No. 31, excepting Patient No. 13, had engaged in dishonorable, unethical or unprofessional conduct likely to deceive, defraud or harm the public or any member thereof, and was is in violation of 11 CSR 1A 12.1(e).

85. Dr. Doyle did opine that the Respondent was not in violation of the provisions of 11 CSR 1A 12.1(v) in that he did not exercise influence over his patients in such a manner as to exploit them for financial gain of a third

party. While Dr. Del Giorno did prescribe drugs in excessive and inappropriate quantities, there was nothing to suggest that there was a deliberate exploitation for financial gain. He also found no evidence that the Respondent was in violation of 11 CSR 1A 12.2(a)(A), prescribing controlled substances with the intent or knowledge that they would be used other than medicinally or for an accepted therapeutic purpose; nor did he find any evidence that allowed him to conclude that the Respondent intended to evade any law with respect to the sale, use or disposition of controlled substances, as prohibited by 11 CSR 1A 12.2(a)(B).

86. Dr. Doyle was emphatic, however that in his opinion the Respondent, generally, in his treatment of Patients No. 1 through No. 31, excepting Patient No. 13, engaged in dishonorable, unethical or unprofessional conduct by prescribing medications in amounts that he knew or had reason to know under the attendant circumstances were excessive under accepted and prevailing medical practice and standards, and is thus in violation of 11 CSR 1A 12.2(a)(D). Dr. Doyle found this pattern was prevalent in at least half of the cases he reviewed from Dr. Del Giorno's office.

87. Dr. Doyle testified in his opinion that Respondent's conduct had the effect of bringing the medical profession into disrepute as a result of his departure from or failure to conform to the standards of acceptable and prevailing medical practices and from his failure to conform to the current principles of medical ethics of the American Medical Association. As

such, he opined that the Respondent was in violation of 11 CSR 1A 12.2 (d). However, Dr. Doyle did not find that Dr. Del Giorno calculated or intended to bring disrepute upon the medical profession.

88. The Board's expert testified that in his opinion the Respondent in his care for Patients No. 1 through No. 31, excepting Patient No. 13, committed a serious act or a pattern of acts during the course of his medical practice which, under the circumstances, would be considered to be gross incompetence, gross negligence or malpractice, including the performance of any unnecessary service or procedure, all in violation of 11 CSR 1A 12.2(c).

89. The Board's expert testified that in his opinion the Respondent in his care for Patients No. 1 through No. 31, excepting Patient No. 13, engaged in unprofessional conduct, including but not limited to any departure from or failure to conform to the standards of acceptable and prevailing medical practice, irrespective of whether or not the patient is injured thereby or has committed any act contrary to honesty, justice or good morals where the same is committed in the course of his practice or otherwise and whether committed within or without this State, and was thus in violation of 11 CSR 1A 12.1(j).

90. Dr. Doyle testified that his opinions given were given to a standard of high probability, a reasonably certain standard, and to the clear and convincing standard. He restated the conclusion noted at the end of his report, that Dr. Del Giorno's license be restricted permanently to not allow the

prescribing of controlled substances. Dr. Doyle did not take any position as to whether the Respondent's license should be revoked.

91. The Respondent, Dr. Del Giorno, took the stand and testified as to his education, training and practice. He noted that he had one previous disciplinary matter in front of the Board and was required to take and pass the SPEX, which he did. He also acknowledged that the charts entered into evidence by the Board were those of patients he had treated at one time.

92. The Respondent testified that his medical judgment has not been perfect, but not necessarily with the patients reflected by the evidence presented by the Board. He admitted that he was initially too lax in monitoring his patients, at the time. As early as 2004 he recognized the "13 month year" issue was a potential problem and he attempted to address it. Unfortunately, his steps to rectify the problem were not successful. Dr. Del Giorno felt that doing routine urine drug screens on patients not showing any signs of abuse was putting an unnecessary financial burden on the patient.

93. Respondent testified that he thought the Board of Pharmacy Reports are inaccurate at times. He noted that during a 30 month period he had individual visits of between 9,700 and 10,500 in his office and that only one tenth of one percent ended up in the Emergency Room with an overdose.

94. The Respondent admitted that he should have been more diligent with Patient No. 4; that he should have been more diligent in obtaining follow-up labs and an echo as requested in relation to Patient No. 6; and that he missed a 2003 report that Patient No. 8 had a positive drug screen for THC, which he deemed an oversight. Dr. Del Giorno testified that he received a discharge summary in December 2005 that mentioned cocaine in relation to Patient No. 8 and admitted that he should have called the hospital for the lab report or relied on that report and that he mistakenly dismissed the severity of the episode. He acknowledged that he continued to prescribe controlled substances to this patient.

95. Respondent testified that Patient No. 9 admitted to using street drugs, had a urine drug screen positive for Benzodiazepines and an equivocal finding as to Methadone. He confirmed that Patient No. 9 reported in February 2007 she had lost her medication; that in March 2007 he received a call that this patient was selling her medication and that he did not require a urine drug screen because the patient was not under a pain management contract and he could not force her to take one. The Respondent wrote to the Complaint Committee that he should have retested her sooner after the equivocal Methadone results and that this was an error in judgment.

96. Respondent testified that in relation to Patient No. 12 he should have done a urine drug screen when she returned from Ohio, but he was more concerned with her blood pressure. He admitted that Patient No. 12, a

woman in her twenties, committed suicide using medication prescribed to her by him.

97. Respondent admitted that he had not always been truthful in his professional life and that he had forged or altered a certificate of insurance to misrepresent to City Hospital that he had liability insurance when, in fact, he did not. Respondent admitted that he did this knowingly and willfully.

98. After the hearing a briefing schedule was established. Both parties timely submitted their proposed findings of facts, conclusions of law and arguments.

DISCUSSION

Inasmuch as this is a disciplinary proceeding, the Board of Medicine has the burden of proving the charges alleged against Louis J. Del Giorno, M.D., in its Complaint and Notice of Hearing. Disciplinary action against a person licensed by the Board must be predicated upon clear and convincing proof. *Webb v. W.Va. Board of Medicine*, 569 S.E.2d 255, 231 (W.Va. 2002).

The provisions of *W.Va. Code* § 30-3-14(c) permit the West Virginia Board of Medicine to discipline a physician for violation of any applicable rule, law or policy that governs the practice. Disciplinary action must be predicated upon clear and convincing proof. *W.Va. Code* § 30-3-14(c); *Webb v. W.Va. Board of Medicine*, 569 S.E.2d 255, 231 (W.Va. 2002).

The Board alleged that Dr. John Del Giorno failed to practice medicine with that level of care, skill and treatment recognized by a reasonable, prudent

physician engaged in the same or similar specialty as being acceptable under similar conditions or circumstances, in violation of *W.Va. Code* §30-3-14(c)(17) and 11 CSR 1A §12.1(x); that the Respondent demonstrated professional incompetence in violation of *W.Va. Code* §30-3-14(c)(20) and 11 CSR 1A §12.1(i); that he prescribed prescription drugs in an manner other than in good faith and in a therapeutic manner in accordance with accepted medical standards in violation of *W.Va. Code* § 30-3-14(c)(13), 11 CSR 1A §§12.1(e) and (v) and 11 CSR 1A §§12.2(a)(A), (B) and (D); that he engaged in unprofessional, unethical and dishonorable conduct of a character likely to harm the public, which said conduct had the effect of bringing the medical profession into disrepute in violation of *W.Va. Code* §30-3-14(c)(17) and 11 CSR 1A §12.1(e) and (j) and §12.2.(d); that he failed to keep adequate written records justifying the course of his treatment in violation of *W.Va. Code* §30-3-14(c)(11) and 11 CSR 1A §12.1(u); and/or that he committed acts and/or a pattern of acts during the course of his medical practice which, under the attendant circumstances, are considered to be grossly incompetent, grossly ignorant and grossly negligent and/or committing malpractice in violation of *W.Va. Code* § 30-3-14(c)(17) and 11 CSR 1A §§12.1(e) and 12.2(c).

Over the course of several days the Board of Medicine presented the testimony from various witnesses, submitted copies of evidentiary depositions of even more witnesses and tendered boxes of evidence. The Respondent testified on his own behalf and conducted his own cross-examination, but did not present any other witness. In particular, the Respondent failed to present any expert

witness to testify on his behalf or to refute the testimony of the Board's expert witness, Dr. Daniel Doyle.

The evidence clearly established that the Board first became aware of a problem with the Respondent when it received a letter from Dr. LaRusso noting that the emergency room physicians in his practice found an alarming pattern of drug overdoses in patients who claimed Dr. Del Giorno was their treating physician. The evidentiary testimony of these various physicians established that they had a legitimate concern, and that the letter to the Board was well-founded. The Responded objected to the testimony of Dr. LaRusso and the other physicians, arguing that their testimony was based on hearsay and inadmissible. However, as noted previously, the objection is overruled. The facts presented by the physician witnesses did not establish that there was a problem with Dr. Del Giorno's practice – they merely formed a basis for the Board to conduct its own investigation. That investigation, in turn, produced the medical records, Board of Pharmacy reports and other evidence that formed the basis of the Complaint. That evidence also formed the basis for the report of the Board's expert witness, Dr. Doyle.

The testimony of an expert witness can be crucial in any matter, especially those that involve complex professional practices or standards. Determinations as to the appropriateness of a medical professional's conduct relative to the standards included in the statute and applicable rules may be made by the Board without the assistance of expert testimony. *Mingo County Medical Society v.*

Simon, 20 SE2d 807 (W.Va. 1942). The testimony of an expert witness may often be a deciding factor to the trier of fact.

The Board's expert, Dr. Daniel Doyle, was very credible and his testimony was soundly based and reliable. With an impressive resume and credentials, Dr. Doyle was able to view the actions of the Respondent from an objective, professional standpoint of a family practitioner with much experience in chronic pain management and a working knowledge of drug diversion practices of patients in this state. Dr. Doyle carefully reviewed the allegations of the Board and the evidence presented to him, and found that Dr. Del Giorno had indeed violated several statutes and rules. He also found that the Respondent had <u>not</u> violated certain other rules, which makes his opinion obviously less biased than alleged by the Respondent.

The medical records submitted by the Board of patients treated by Dr. Doyle were voluminous and presented undisputed evidence of the pattern and practice of the Respondent in treating patients for chronic pain. After conducting a review of these records, Dr. Doyle found that the Respondent exhibited an almost careless pattern of treating patients who were, or became, dependent upon controlled substances. Even though many patients confessed at the initial visit that they used various drugs or alcohol on a recreational basis, the Respondent gave them prescriptions for a controlled substance without first obtaining prior medical records or even a baseline urine drug screening. He continued to prescribe excessive amounts of controlled substances or other "dangerous" drugs without running any interventions, without demanding drug

screenings or without any noted in-depth consultations with the patients. In many cases, red flags were flying everywhere, and the Respondent seemed oblivious.

Dr. Doyle opined that Dr. Del Giorno violated numerous provisions of the West Virginia Medical Practice Act and various rules of the West Virginia Board of Medicine. He further opined that Dr. Del Giorno should be restricted in his ability to prescribe controlled substances. As a whole, Dr. Doyle's opinion that the actions of the Respondent constituted a violation of numerous rules, statutes and standards, given to a degree of high probability, was credible and reliable.

The Respondent did not present any evidence, expert or otherwise, to refute this testimony. He appeared without counsel and acted as his own witness and attorney. Dr. Del Giorno's primary defense was geared towards showing bias on the part of the Board's witnesses, pointing out the emergency room physicians' lack of expertise in pain management and their lack of knowledge about his private practice. His brief argued that the emergency room physicians were unable to show that he ever deviated from the proper standard of care. What the Respondent failed to realize, however, was that the letter from Dr. LaRusso did not form the basis of the Board's Complaint – rather it formed the basis for the Board's investigation. Moreover, those physicians were not the Board's expert witnesses, and their opinions of the Respondent's practices were not given the weight accorded to Dr. Doyle.

The Respondent attempted to discredit the testimony of the Board's investigator, Leslie Higginbotham, and of Mr. Potter from the Board of Pharmacy,

to no avail. The testimony of both witnesses reflected the standard practices of both Boards, and there is no evidence that makes their testimony anything other than reliable and credible.

The Respondent also argued that Dr. Daniel Doyle, the Board's expert witness, was not an unbiased, objective witness and that his testimony was prejudicial because of the evidence upon which he relied in forming his opinion. However, Dr. Del Giorno did not offer any evidence that contradicted the testimony of Dr. Doyle, did not present any contrary expert testimony, and failed to show how Dr. Doyle's testimony was anything other than credible.

The Respondent attempted to show that he followed industry guidelines in prescribing medications; that he gave signed notices to patients in order to avoid the "13-month year" pattern; that he discharged numerous patients for suspected drug abuse or diversion and that he rejected many patients after performing a pre-screening. However, evidence that the Respondent did something correctly does not negate the fact that in many instances he did something incorrectly, often with fatal results. In many of the cases, the Respondent admitted that he failed to act in a professional manner and could have done something more.

As a physician who specializes in chronic pain management, Dr. Del Giorno is correct in stating that he would obviously and necessarily be prescribing a great number of controlled substances. However, the manner in which he prescribed these medications, his failure to properly screen, intervene and follow-up with his patients, and his habit of summarily discharging patients

with obvious addiction problems is troubling. Likewise, while the Respondent appeared earnest and forthright in his testimony and sincere in his summary arguments, there are several factors that raise credibility issues. The "tax problems" that resulted in his loss of medical licenses in at least two states and the admission that he falsified insurance documents to City Hospital do not make his testimony the most reliable.

The medical records of the patients treated by the Respondent and the records from the Board of Pharmacy form clear evidence of the pattern and practice of Dr. Del Giorno in prescribing medications for pain management. Unfortunately, those records also reflect an almost careless manner of prescribing controlled substances and an indifference to the overall well-being of the patients affected. The number of the Respondent's patients who presented at the emergency room with overdoses, some of them fatal, is a red flag that the Board must not ignore if the public is to be properly protected.

The Board has shown by clear and convincing evidence that Dr. Del Giorno's practice of prescribing controlled substances does not rise to the level of professional skill and competence inherent to a physician who holds himself out to be a specialist in chronic pain management. While the general medical skills of Dr. Del Giorno may be sufficient, his knowledge and skill with regard to issuing prescriptions for controlled substances is clearly lacking.

There are several mitigating circumstances, however, that should be considered. Dr. Del Giorno has practiced medicine for 28 years. Although he lost his licenses in two other states as a result of "tax matters" there is no

evidence that he has had any malpractice actions against him. When the Board of Medicine had concerns about his initial foray into pain management, Dr. Del Giorno willingly complied with the required training and has attempted to self-educate himself in the area of pain management. He is a sole practitioner and, as he has noted, his entire livelihood depends on this decision.

The Board's expert witness, Dr. Doyle, did not offer an opinion as to whether the Respondent's medical license should be revoked. Rather, he opined that Dr. Del Giorno's prescriptive abilities should be curtailed. Counsel for the Board argues that the Respondent's medical license should be revoked.

The undersigned agrees with Dr. Doyle, and therefore recommends that the Respondent be placed on PROBATION for a period of no more than five (5) years under terms to be decided by the Board of Medicine; that the Respondent's medical license be RESTRICTED PERMANENTLY to not allow the prescribing of controlled substances; and that the Respondent be assessed the reasonable costs and expenses of this matter.

CONCLUSIONS OF LAW

1. The Respondent, Louis John Del Giorno is a physician licensed in the State of West Virginia. The West Virginia Board of Medicine is the agency of the State charged with the licensure and discipline of physicians pursuant to the provisions of *W.Va. Code* §30-3-14 and 11 CSR 1A.
2. The Petitioner, the West Virginia Board of Medicine, has jurisdiction over the subject matter and over the Respondent. The Petitioner bears the burden of proving the allegations in the Complaint and Notice of Hearing

by clear and convincing evidence. *W.Va. Code* §30-3-14(b); *Webb v. West Virginia Board of Medicine*, 569 S.E.2d 225, 231 (W.V. 2002).

3. The express purpose of the West Virginia Medical Practice Act is to provide for the licensure and professional discipline of physicians and to provide a professional environment that encourages the delivery of quality medical services within this state. *W.Va. Code* §30-3-2.
4. The practice of medicine is a privilege and the state may attach conditions "onerous and exacting" to this privilege. *Barsky v. Board of Regents*, 111 N.E.2d 222 (N.Y. 1953, *reh. den.* 112 N.E. 2d 773, *affirmed* 347 U.S. 442, 74 S. Ct.650), *cited* in *West Virginia Board of Medicine v. Clayton E. Linkous, Jr., M.D.*, (1991); *West Virginia Board of Medicine v. Rahmet Muzaffer, M.D.* (1998), *West Virginia Board of Medicine v. Francesco Quarequio, M.D.* (1999). *See also, W.Va. Code* §30-1-1a, §30-3-1; *State ex rel Deleno H. Webb, M.D. v. West Virginia Board of Medicine,* 506 SE2d 830 (WV 1998).
5. The inherent object of the underlying statute regulating the practice of medicine is the preservation of the public health. *Vest v. Cobb,* 76 S.E.2d 885 (WV 1953), *citing Dent v. State of West Virginia*, 129 U.S. 114, 123 S. Ct. 231 (1889); *West Virginia Board of Medicine v. Magdi Z. Fahmy, M.D.* (1993); *West Virginia Board of Medicine v. Thomas J. Park, M.D.* (1994); *West Virginia Board of Medicine v. Francesco Quarequio, M.D.* (1999), *West Virginia Board of Medicine v. Frank Lenous Turner, D.P.M.* (2004).

6. The Board presented the expert testimony of Dr. Daniel Doyle, and it was credible, clear and convincing and is entitled to great weight under the provisions of Rule 702 and 704 of the *W. Va. Rules of Evidence* and the Board's standard practice and custom. The testimony was not refuted in any way by the Respondent, and is thus deemed reliable. *West Virginia Board of Medicine v. David C. Shamblin, M.D.*, (1989); *West Virginia Board of Medicine v. Thomas J. Park, M.D.* (1994); *West Virginia Board of Medicine v. Thomas E. Mitchell, M.D.* (1995); *West Virginia Board of Medicine v. Boonlua Lucktong, M.D.* (1996); *West Virginia Board of Medicine v. Paul T. Healy, M.D.* (1997), *West Virginia Board of Medicine v. Swaraj S. Rikhy, M.D.* (1997), *West Virginia Board of Medicine v. Francesco Quarequio, M.D.* (1999), *West Virginia Board of Medicine v. Frank Lenous Turner, D.P.M.* (2004).
7. Expert testimony is not required to establish that a physician's conduct is unprofessional. Even without the opinion of Dr. Doyle, the Board established by clear and convincing evidence that the Respondent's conduct was unprofessional and in violation of the applicable Board Rules. *Mingo County Medical Society v. Simon,* 20 S.E.2d 807 (W.Va. 1942); *West Virginia Board of Medicine v. Rahmet Muzaffer, M.D.* (1998); *West Virginia Board of Medicine v. Francesco Quarequio, M.D* (1989). *See also*, *Pons v. Ohio State Medical Board*, 614 N.E.2d 748, (1991), (requiring due deference to the Board's interpretation of ethical requirements of its profession, at Syllabus point 4.)

8. In an administrative proceeding, the trier of fact is entitled to take into account the credibility and demeanor of witnesses, and the trier of fact is uniquely situated so as to make such determinations. *Webb v. West Virginia Board of Medicine*, 569 S.E.2d at 232; *In Re Queen,* 473 S.E.2d. 481, fn 6 (W.V. 1996.)
9. The Board has shown by clear and convincing evidence that the Respondent's care was below the level of care, skill, and treatment which is recognized by a reasonable and prudent physician engaged in the same or similar specialty as being acceptable under similar conditions or circumstances in violation of 11 CSR 1A §12.1(x).
10. The Board has shown by clear and convincing evidence that the Respondent has demonstrated professional incompetence and is in violation of *W.Va. Code* §30-3-14(c)(20).
11. The Board has shown by clear and convincing evidence that the Respondent prescribed, dispensed, administered or prepared a prescription drug, including any controlled substance, other than in good faith and in a therapeutic manner and thus is in violation of *W.Va. Code* §30-3(c)(13).
12. The Board has shown by clear and convincing evidence that the Respondent has demonstrated a lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients, and thus is in violation of 11 CSR 1A §12.1(i).

13. The Board has shown by clear and convincing evidence that the Respondent has engaged in dishonorable, unethical conduct likely to harm the public or any member thereof, and thus is in violation of 11 CSR 1A §12.1(e).

14. The Board has shown by clear and convincing evidence that the Respondent has engaged in unprofessional, unethical conduct in prescribing in the amounts the licensee knows or has reason to know under the attendant circumstances that the amounts prescribed or dispensed are excessive under accepted and prevailing medical practice and standards, and is thus in violation of 11 CSR 1A §12.2(a)(D).

15. The Board has shown by clear and convincing evidence that the Respondent has engaged in conduct that has had the effect of bringing the medical profession into disrepute and is thus in violation of 11 CSR 1A §12.2 (d).

16. The Board has shown by clear and convincing evidence that the Respondent committed a serious act or a pattern of acts committed during the course of his or her medical or podiatric practice which under the circumstances would be considered to be gross incompetence, gross negligence or malpractice, including the performance of any unnecessary service or procedure and is thus in violation of 11 CSR 1A §12.2(c)

17. The Board has shown by clear and convincing evidence that the Respondent engaged in unprofessional conduct, including but not limited to any departure from or failure to conform to the standards of acceptable

and prevailing medical practice, irrespective of whether or not the patient is injured thereby or has committed any act contrary to honesty, justice or good morals where the same is committed in the course of his practice or otherwise and whether committed within or without this State, and is thus in violation of 11 CSR 1A §12.1(j)

18. The Board has shown by clear and convincing evidence that the Respondent violated various Rules of the Board and thus violated W.Va. Code § 30-3-14(c)(17).

19. Under the provisions of 11 CSR 1A §12.3, the license of a physician shall be restricted, suspended or revoked by the Board in accordance with all of the alternatives set out at *W.Va. Code* §30-3-14(i), when after due notice and a hearing it is found that the physician has violated any of the provisions of 11 CSR 1A §12.

20. The majority of the charges in the Complaint and Notice of Hearing have been proven by the Board, clearly and convincingly.

RECOMMENDED DECISION

Based upon the foregoing findings of fact and conclusions of law, even taking into consideration mitigating factors, the undersigned Hearing Examiner hereby recommends to the West Virginia Board of Medicine that it is proper and essential and in the public health, interest, welfare and safety that Louis J. Del Giorno, M.D. be placed on PROBATION for a period of no more than five (5) years and that the Respondent's medical license be RESTRICTED PERMANENTLY to not allow the prescribing of controlled substances.

The undersigned further recommends that the Respondent shall be required to pay the costs and expenses of these proceedings, including but not limited to fees and expenses of security, the Hearing Examiner, the court reporter, attorney advisor, and expert witness, and all other costs of investigation and prosecution of this matter, to be paid by the Respondent to the Board within thirty (30) days of issuance of an invoice by the Board.

Respectfully submitted this 24th day of March 2010.

Jennifer Narog Taylor, WVSB 4612
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CERTIFICATE OF SERVICE

I, Deborah Lewis Rodecker, Counsel for the Board of Medicine, do hereby certify that I have served the foregoing Order on Louis Del Giorno, M.D., by mailing a copy in the United States mail, postage prepaid, by certified mail, this 14th day of May, 2010, addressed to Dr. Del Giorno as follows:

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